

FM 8-15

DEPARTMENT OF THE ARMY FIELD MANUAL

**MEDICAL SERVICE
IN**

**DIVISIONS, SEPARATE BRIGADES
AND THE ARMORED CAVALRY REGIMENT**

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MEDICAL SERVICE IN DIVISIONS, SEPARATE BRIGADES, AND THE ARMORED CAVALRY REGIMENT

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*This manual supersedes chapters 4 through 12 and chapter 21; section III, chapter 13; and sections I, II, IV, chapter 22 of FM 8-10, 3 November 1959; FM 8-15, 30 November 1961, including C 1, 7 October 1963; and rescinds TT 8-15-1, 20 January 1966.

CHAPTER 1

INTRODUCTION

Section I. GENERAL

1-1. Purpose and Scope

a. This manual is a guide for commanders, staffs, subordinate leaders, and troops of the Army Medical Service (AMEDS) assigned to, or supporting, divisions, separate brigades, and the armored cavalry regiment. It provides information on the organizational characteristics of medical units or elements and the basic doctrine concerning their use in varying tactical situations.

b. The organization, mission, capabilities, and internal activities are described in broad terms. Unit level medical service as well as operations in special environments (e.g., jungle, mountain), and stability operations, thoroughly covered in detail in other manuals, are discussed briefly in order to supplement doctrine common to all areas of operation.

c. The information presented is applicable to general, limited, and cold war situations, including stability operations, except as specifically stated in chapter 8, which sets forth the doctrine for management of mass casualties.

d. This manual is in consonance with the following International Standardization Agreements which are identified at the beginning of each appropriate chapter:

(1) STANAG 2061 (SOLOG 66) (SEASTAG 2061) (CENTO STANAG 2061), Procedures for Disposition by Medical Installations of Allied Patients.

(2) STANAG 2128, Medical and Dental Supply Procedures.

(3) STANAG 2075 (SOLOG 74) (SEASTAG 2075), Patient Reporting by Medical Treatment Facilities.

(4) STANAG 2087 (SEASTAG 2087), Medical Employment of Helicopters in Ground Warfare.

1-2. Definitions

The terms used in this manual are consistent with AR 320-5. Other terms are explained when introduced.

1-3. Changes

Users of this manual are encouraged to submit recommendations to improve clarity or accuracy. Comments should be keyed to the specific page, paragraph, and line of the text in which the change is recommended. Reasons should be provided for each comment to insure understanding and complete evaluation. Comments should be forwarded direct to the Commanding Officer, United States Army Combat Developments Command Medical Service Agency, Fort Sam Houston, Texas 78234. Originators of proposed changes which will constitute a significant modification of approved Army doctrine may send an information copy, through command channels, to the Commanding General, United States Army Combat Developments Command, Fort Belvoir, Virginia 22060, to facilitate review and followup.

Section II. FIELD MEDICAL SERVICE

1-4. Missions

The Army Medical Service is a supporting service of the combat elements of the Army. The mission of the medical service is to conserve manpower by planning, recommending,

and supervising the implementation of measures necessary for safeguarding the health of the troops, and for providing medical treatment and rapid evacuation of the sick and wounded.

1-5. Functions

The general functions of the medical service are acquisition of the sick and wounded; treatment; evacuation; preventive medicine; medical supply and maintenance; dental, veterinary, laboratory, and optometric services; medical intelligence; medical administration; and command and control of medical units. In addition, medical assistance to civilians is provided within the limits of available resources.

1-6. Principles of Medical Service

The operation of medical service is based upon fundamental principles as follows:

a. Continuity. Medical service must be continuous. Interruption in continuity of treatment will cause an increase in morbidity and mortality. Once begun, treatment does not terminate until the patient has been returned to duty or discharged from the service. Procedures should be standardized at each level to assure accomplishment of all required treatment and other medical functions appropriate to the means and the situation at that level.

(1) The hospitalization - evacuation system is based on the doctrine that subordinate elements are supported by the next higher echelon. Usually no level of medical service is given the responsibility for evacuation beyond its rearmost medical facility.

(2) No patient is evacuated further to the rear than his physical condition warrants or the military situation requires. The evacuation policy of the command designates the maximum period during which patients may be retained for treatment within the command. Patients who cannot be returned to duty within the prescribed time are evacuated.

(3) The medical plan must be simple, particularly in the combat area. Facilities must not be immobilized by long and complicated procedures. Except for minor injuries or illnesses which can be treated with minor surgery or available medicines, treatment in forward areas is usually limited to those emergency measures which will preserve life and limb and prepare the patient for further evacuation.

b. Control. Control of medical resources must rest with the medical commander or medical staff officer.

(1) If the medical service is to respond to the commander's plans in a timely manner, the surgeon responsible for its direction must be influential in the operations of medical units. For this reason, medical units are not attached if their mission can be accomplished by placing them in either direct or general support.

(2) Since the objective of military medicine is to conserve trained manpower, medical means must be employed to do the most good for the greatest number. When a wide disparity exists between the requirements for medical service and the means available, it may be necessary to favor those patients who can be returned to immediate duty, rather than those more seriously injured.

(3) The treatment to be performed at each level of medical service must be commensurate with its available resources. Medical support is not unlimited. It is essential, therefore, that control be retained at the highest medical level consistent with the tactical situation.

c. Proximity. The medical means must be as close to casualties as the tactical situation permits. Early collection, sorting, and evaluation must be provided.

(1) In reducing morbidity and mortality, the speed with which medical treatment can be initiated is extremely important. When planning to support a tactical operation, the medical planner is confronted with two alternatives. He must either move the patient to a medical treatment facility, or move the medical facility to the patient. Two factors will govern the choice—the military situation, and the condition of the patient. The medical facility must not be located so far forward as to interfere with combat operations or to subject it to enemy interference; yet, it must not be located so far to the rear that the patient's chances for normal recovery and survival will be unnecessarily jeopardized. Thus, a location which provides close medical support where helicopters are used is quite different from that required when evacuation is provided by litterbearers operating over difficult terrain.

(2) In forward areas, medical support is provided by locating medical treatment facilities as far forward as possible, moving as necessary to maintain contact, and by rapid evacuation of patients. When evacuation time exceeds that period considered necessary to hold morbidity and mortality to a minimum, the medical treatment facility must be moved closer to the patient, or faster, more efficient evacuation must be provided. In either case, patients and treatment facilities must be brought together as promptly as possible.

d. Flexibility. Medical service must be flexible. A change in tactical plans or operations may require redistribution of medical support. The medical commander and the medical staff planner must be able to shift medical support to meet the changing requirements. Alternate plans and plans for a medical reserve are essential. No more medical troops should be committed nor medical facilities established than required for the task at hand or for the obvious needs of the immediate future. Once committed, a limitation is imposed on the availability of the medical unit for other employment.

e. Mobility. Contact with supported units must be maintained; therefore, medical troops must have the same mobility as the units supported. Mobility may be retained by the timely and rapid evacuation of patients.

(1) The mobility of a unit is measured by the extent to which it can move its personnel and equipment with organic transportation.

(2) Once entirely committed, the mobility of a medical unit can be regained only by the prompt evacuation of patients. When the mobility of a medical unit is jeopardized by the accumulation of patients, it may be necessary to leave a small holding detachment with patients when the main part of the unit is moved.

f. Conformity. Conformity with the tactical plan is one of the most fundamental elements in the provision of field medical support. It is only by analyzing the commander's plan of operation that the medical planner can determine his requirements for medical units and prepare an adequate plan for medical support. Medical service must always be available in

the right place, at the right time, and in the right amounts.

1-7. Organization

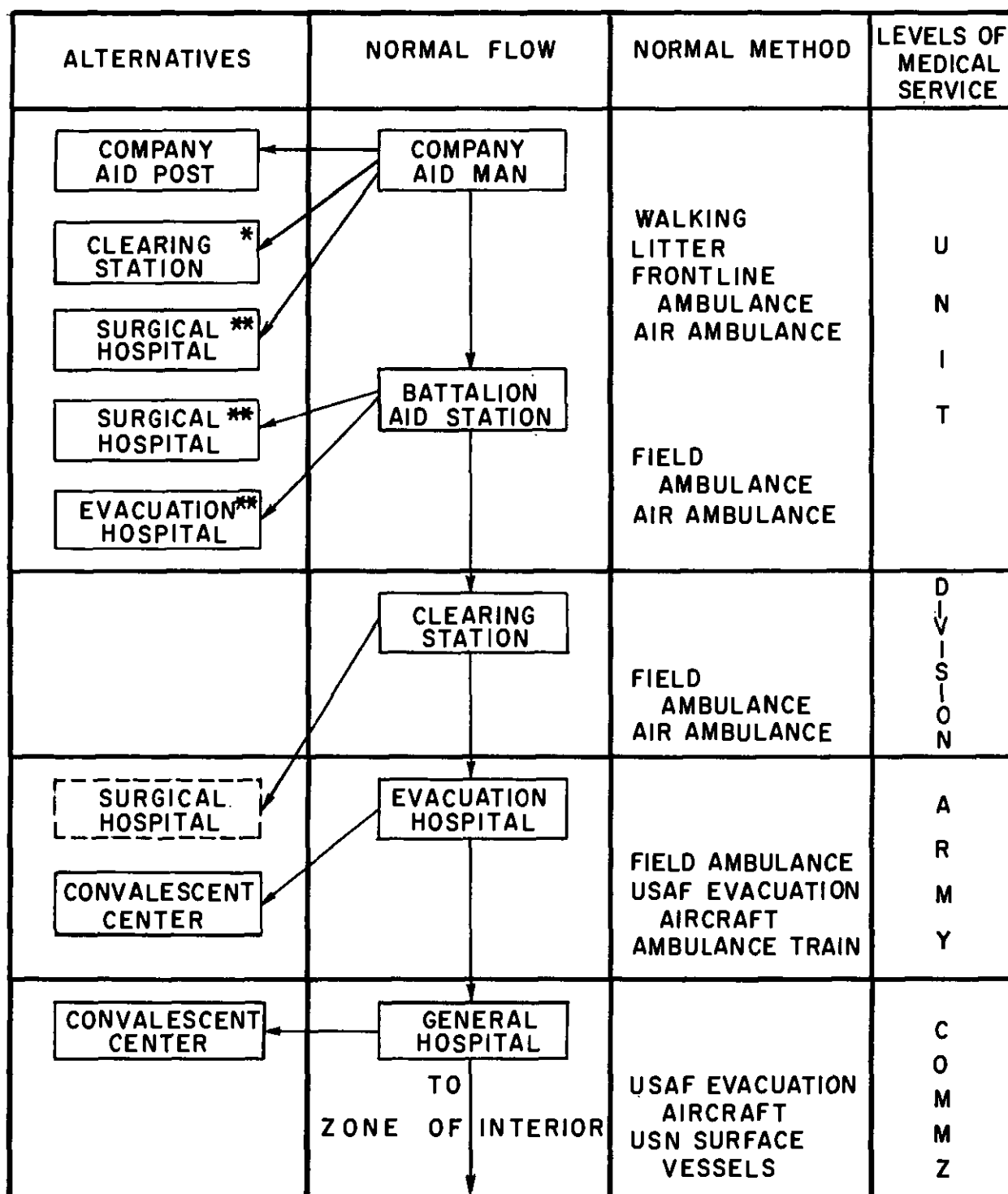
a. General. The field medical service organization generally parallels the tactical organization in a theater of operations. The functional levels of medical service are unit, division, field army, and COMMZ levels. Levels of medical service extend rearward from the line of contact in an integrated and continuous system, to the zone of interior (fig. 1-1).

(1) *Unit level.* Unit, or the first level of medical service, includes preventive medicine activities, acquisition of the sick and wounded, emergency medical treatment (EMT), and evacuation from the point of onset of illness or injury to the point of initial professional treatment at the aid station. Unit level medical service is usually provided by a medical platoon or section of the headquarters company (battery or troop) of combat and combat support battalions (squadrons).

(2) *Division level.* Division, or second level, medical service has the primary functions of evacuating patients from unit level aid stations and providing further medical treatment at clearing stations. Division level medical service is provided by the division medical battalion. In separate brigades and the armored cavalry regiment, division level medical service is provided by assigned elements or attached medical companies.

(3) *Field army level.* Field army, or third level medical service, has the main functions of evacuating patients from division and non-divisional units and providing resuscitative and definitive medical treatment. Field army medical service is provided by the field army medical brigade.

(4) *Communications zone level.* Communications zone, or the fourth level of medical service, has the functions of surface evacuation of patients from the field army; providing area medical service in the COMMZ; and providing definitive medical treatment at fixed hospitals. Air evacuation from the field army is a responsibility of the Air Force. Communications zone medical service is provided by the theater army medical command.



* Division level

** Army level

[] May be located in division area

Figure 1-1. Normal flow of evacuation.

b. Area Medical Service. Medical service, including dental and veterinary service, is provided on an area basis. This concept of medical service involves support responsibility by geographical area. Area medical service is used in supporting forces in the combat and the communications zones that do not possess organic medical support. Area dental service provides routine treatment to all military personnel in

the combat and communications zones. Allocations of medical units for this service are based upon troop strength, and are established where and when requirements indicate. Area veterinary services provides subsistence inspection, animal care, control of food and animalborne diseases and other assigned preventive medicine services.

Section III. THE DIVISION

1-8. General

The division is the basic Army unit containing combined arms and services, and has both tactical and administrative responsibilities. The division may be tailored for specific tasks or environment and is capable of conducting independent operations or operating as part of a larger force.

1-9. Organization

a. General. The division consists of a relatively fixed command, staff, reconnaissance, combat support, and combat service support structure (fig. 1-2). Combat battalions are assigned in types and numbers appropriate to the division's mission and operational environment. Determination of the types and numbers of combat battalions in a division is called

"tailoring" (FM 61-100).

b. Types. The preponderance of a particular type of combat battalion assigned determines the type of division (i.e., infantry battalions predominate in an infantry division). Types of divisions are—

(1) *Infantry.* Mix of infantry and tank battalions (fig. 1-2).

(2) *Infantry (mechanized).* Mix of mechanized infantry and tank battalions (fig. 1-2).

(3) *Airborne.* Airborne infantry battalions (fig. 1-2).

(4) *Airmobile.* Airmobile infantry battalions (fig. 1-2).

(5) *Armored.* Mix of tank and mechanized infantry battalions (fig. 1-2).

Section IV. SEPARATE BRIGADES AND THE ARMORED CAVALRY REGIMENT

1-10. General

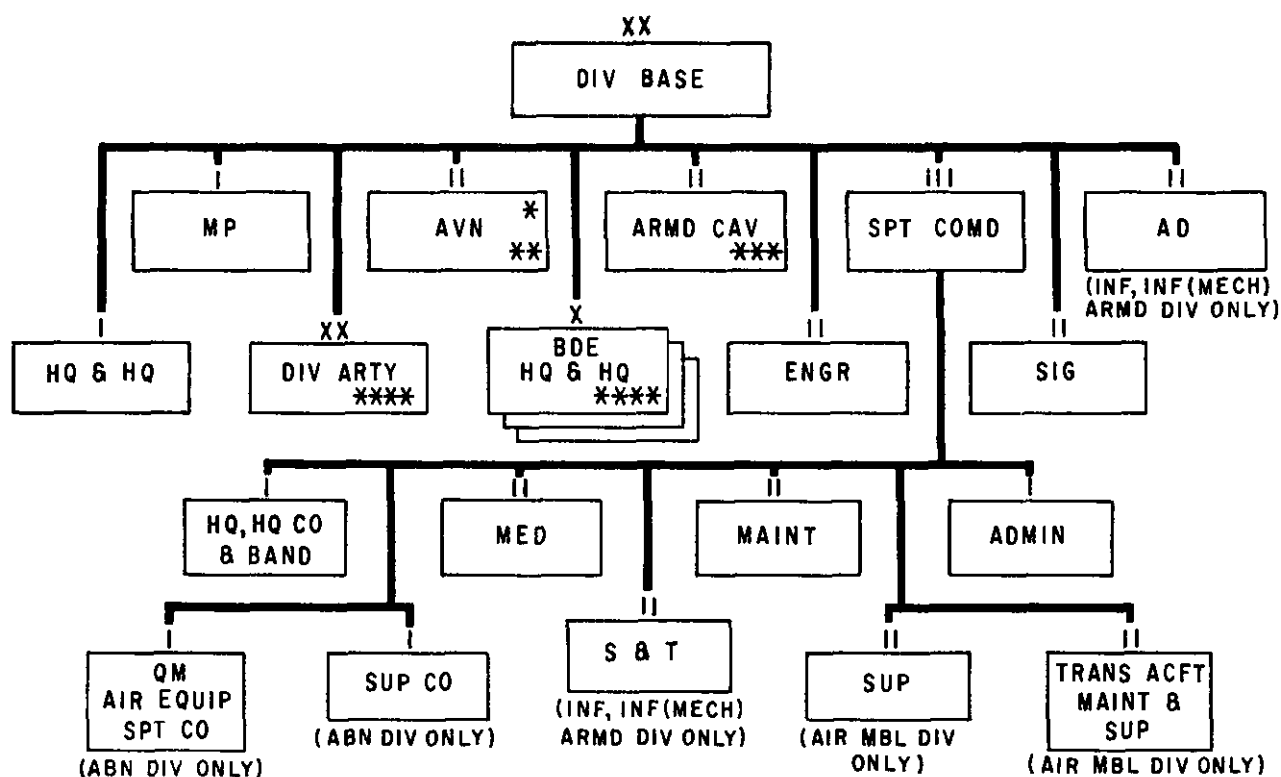
Separate brigades and armored cavalry regiments are employed independently or as part of a larger force. The armored cavalry regiment is normally employed as the reconnaissance and security force of an Army corps.

1-11. Organization

a. Separate brigades are organized similar-

ly to a division brigade, except for the inclusion of combat support and combat service support elements to make them essentially self-sufficient.

b. The armored cavalry regiment consists of a fixed number of armored cavalry squadrons and combat support units.



- * APPLICABLE ONLY TO INFANTRY, AIRBORNE DIVISIONS
- ** AVIATION GROUP IN AIRMOBILE DIVISION
- *** AIR CAVALRY SQUADRON IN AIRMOBILE DIVISION
- **** NUMBER AND TYPE BATTALIONS MAY VARY

Figure 1-2. Division base and support command, all divisions.

CHAPTER 2

MEDICAL SERVICE IN THE DIVISION

(STANAG'S 2061, 2075, 2128)

Section I. GENERAL

2-1. Scope

Medical service in the division extends from the forward operational areas of the combat battalions to the division rear boundary.

2-2. Organization

a. Unit-level medical service in combat battalions, some combat support battalions of the division, division headquarters and headquarters company, and division artillery headquarters and headquarters battery is provided by organic medical platoons or sections. Division level medical service is provided by the division medical battalion.

b. Medical service in brigades, division artillery, and aviation groups (airmobile division) is unit level and organic to attached battalions except as stated in *a* above. Each is provided with a command surgeon who exercises staff supervision over the medical service of the command.

c. Medical service for units without an organic medical platoon (section) is discussed in paragraphs 2-22 through 2-24.

2-3. Duties and Responsibilities

a. Division Surgeon. The senior Medical Corps (MC) officer assigned to the division is normally designated the division surgeon. The surgeon is a special staff officer of the division commander and normally functions under the staff supervision of the division G1. Generally, the surgeon's duties are administrative, in that the commander normally charges him with full responsibility for staff supervision to include technical control of all medical service activities in the command, and advisory as a special staff officer. In addition, the surgeon—

(1) Prepares the medical annex to the division standing operating procedures, the medical portion of the staff estimate of the

situation and operations order, and the division medical plan.

(2) Coordinates the operations of unit medical service elements and the division medical battalion through direct contact with surgeons of the brigades, division artillery, engineer battalion, cavalry squadron, aviation group or battalion, and the commander of the division medical battalion.

(3) Coordinates with the corps and field army surgeons concerning the field army level medical support to the division, including reinforcement of division medical units or temporary replacement.

(4) Provides information concerning the current medical situation and division combat operations and plans to field army level medical units operating within the division.

(5) Coordinates with other special and general staff officers on the medical aspects of—

(*a*) Chemical, biological, and radiological defense.

(*b*) Stability operations.

(*c*) Civil affairs.

(*d*) Tactical and technical intelligence.

(*e*) Officer assignment and employment.

(*f*) Enlisted Army Medical Service personnel assignment.

(*g*) Training.

(*h*) Control of critical medical items of equipment and supplies.

(*i*) Logistical support.

(*j*) Medical records and reports.

b. The Medical Special Staff Section. The medical section of the division headquarters contains professional assistants in preventive medicine, aviation medicine, and psychiatry.

An administrative assistant and enlisted staff are also included in the section. When the surgeon is required to be temporarily absent from the command post, the senior Medical Corps officer on the staff normally makes required professional decisions. The commander designates an acting surgeon when the surgeon is absent from the command. Any member of the surgeon's staff may be used as the surgeon's representative on damage control and assessment teams.

(1) The division preventive medicine officer assists the surgeon in the staff supervision of the command preventive medicine program. The preventive medicine officer visits division units to identify actual and potential health hazards; recommends corrective measures and assists in training personnel (e.g., field sanitation teams prescribed by AR 40-5) in disease prevention programs; recommends proper levels of pesticides, repellents, chemicals for water purification, and other supplies and equipment necessary to promote health; and assists the surgeon in the preparation of the command health report. Success in these programs reduces the impact of disease and non-battle injury—both major factors affecting the division's combat strength.

(2) The division psychiatrist assists the surgeon on matters pertaining to morale and the impact of current policies and operations upon the psychological effectiveness of troops. He serves as the professional staff consultant for division medical services on matters of psychiatric importance. The psychiatrist establishes the overall program for the treatment and evacuation of psychiatric patients and assists the surgeon in the staff supervision of a division-wide program to prevent psychiatric disorders.

(3) The division aviation medical officer advises the surgeon and staff on aviation medical matters.

(4) The Medical Service Corps field medical assistant supervises the enlisted staff of the surgeon's section in performing administrative tasks. The medical assistant prepares division periodic and special medical reports required by the division commander and general staff. He is the surgeon's principal assistant in preparing division medical standing

operating procedures and medical estimates. He also provides continuity in the operation of the surgeon's section when the surgeon and other staff officers are absent from the command post.

c. Brigade Surgeon. The brigade surgeon's primary responsibility is to insure that medical support is available and adequate. He provides the brigade commander with information regarding the medical aspects of combat effectiveness within the brigade and performs staff functions similar to those of the division surgeon. In addition, the brigade surgeon—

(1) Implements division medical SOP and the medical portion of the administrative order.

(2) Recommends reallocation of medical resources between battalions.

(3) Monitors requests for aeromedical evacuation originated in subordinate battalions.

(4) Insures that the brigade receives adequate medical support from the division medical battalion.

(5) Provides the division surgeon with information on the brigade's combat operations and plans and the brigade commander's priorities for support of attached maneuver battalions.

(6) Assumes operational control (when directed) of medical units temporarily attached to the brigade.

d. Battalion Surgeon. The duties and responsibilities of the battalion surgeon are described in paragraph 2-6c.

e. Division Artillery Surgeon, Aviation Group Surgeon. Generally, the duties and responsibilities are as discussed in *a* and *c* above. In addition, the division artillery surgeon operates an aid station for the division artillery headquarters.

2-4. Dental Support

Expedient dental care is provided by dental officers assigned to the division. The senior dental officer may be designated the division dental surgeon and serve as dental advisor to the division surgeon. Routine dental care and support for the division is provided by field army units during noncombat periods. The area dental support unit normally designates a

liaison officer to coordinate dental support with the division surgeon.

2-5. Veterinary Support

Veterinary support usually is provided to the division on an area basis. In widely dispersed

or independent operations, it may be necessary to attach veterinary personnel or units to the division. Veterinary support includes subsistence inspection, animal care, and control of food and animalborne diseases.

Section II. UNIT LEVEL MEDICAL SERVICE

2-6. General

a. Functions.

(1) The field medical service system begins at the unit level. In combat, acquisition of sick and wounded casualties from forward locations is closely followed by emergency medical treatment, evacuation, and initial professional treatment. Preventive medicine activities are maintained throughout combat and noncombat periods. During noncombat periods, unit level medical personnel operate a unit dispensary, conduct medical MOS training, and, when required, provide instruction to non-medical personnel in first aid, field sanitation, and personal hygiene procedures.

(2) Unit level medical service may be used in support of existing services and facilities intended for the care of the population of an area, or to provide such services when services are either inadequate or nonexistent. Such employment may be necessary not only in general and limited war, but also in stabilization operations and disaster relief.

b. Organization.

(1) A unit medical section (platoon) is organic to the division headquarters, division artillery headquarters, artillery battalions, combat battalions (i.e., infantry, armored, infantry (mechanized), airborne, and airmobile), the armored or air cavalry squadron, the aviation battalion, the engineer battalion, and the air defense battalion.

(2) The organization of the medical platoon (section) varies with the structure of the parent unit. In general, each may be functionally organized into headquarters, aid station, aid man, and evacuation elements.

c. Unit Surgeon. The Medical Corps officer assigned is designated as the battalion (squadron) surgeon. The battalion (squadron) surgeon has two major areas of responsibility—one as commander of the medical element of the

battalion and the other as the surgeon on the staff of the commander. Responsibilities and functions of the battalion surgeon are essentially as described for the division surgeon. In addition, the battalion surgeon—

(1) Plans and directs the unit level medical support of the battalion.

(2) Assists the S3 in planning and supervising individual and unit training of the battalion medical platoon or section and the training of all other battalion personnel in first aid, military sanitation, personal hygiene, and medical aspects of injury and wound prevention.

(3) Conducts the battalion preventive psychiatry program, including training of battalion troop leaders in their role of preventing psychiatric disorders, especially combat exhaustion.

(4) Provides the battalion commander and staff with current data on the medical aspects of present or anticipated use of chemical and biological agents and nuclear weapons.

(5) Establishes and operates an aid station in the vicinity of the battalion (squadron) command post.

(6) Supervises the administration, maintenance, discipline, organization, and employment of the platoon or section.

d. Employment.

(1) Platoon or section headquarters.

(a) The platoon (section) headquarters operates a command post which is located at the battalion (squadron) aid station site. The command post includes a message center operated under the supervision of the platoon sergeant. Messages received by radio, telephone, or messenger are processed at this point.

(b) The medical platoon (section) headquarters maintains contact with the parent battalion (squadron) headquarters. Avail-

able means of communication include an administrative-logistic radio network, telephone, and written or oral messages.

(c) Headquarters element personnel may also perform additional duties in aid station or evacuation elements.

(d) The battalion (squadron) medical platoon (section) is concerned with two types of supply—general (non-mission) supply for the platoon, and mission (medical) supply for the entire battalion (squadron).

1. *General supply.* General supplies are provided the medical platoon (section) by the battalion (squadron) headquarters company (battery, troop).

2. *Medical supply.* In noncombat conditions, medical supplies are obtained in response to formal requests in the same manner as other supplies. In combat, medical supplies are obtained informally through medical channels, and in the most expeditious manner. Normally, informal requests are submitted through the evacuation system. The aid station will make use of division ambulances returning to the rear as a means of transmitting requests to the division clearing station. Division ambulances will deliver the supplies to the battalion aid station on return trips. The battalion (squadron) medical platoon (section) must avoid accumulating large quantities of supplies that may hamper mobility.

3. *Property exchange.* Whenever a patient is evacuated from one medical facility to another, it is necessary that medical items of equipment such as blankets, litters, and splints remain with the patient. In order to prevent rapid and unnecessary depletion of supplies and equipment, the receiving agency exchanges like property with the transferring agency. This procedure must be practiced to the fullest extent possible through all phases of evacuation from the most forward elements through the fixed hospitals of the communications zone. Medical property accompanying patients of allied nations will be disposed of in accordance with STANAG 2128 (app B).

(2) *Aid man element.*

(a) The aid man element consists of medical aid men attached to each subordinate company, troop, or battery. Aid men are allo-

cated to infantry battalions and armored cavalry squadrons on the basis of one per rifle or cavalry platoon; and to artillery, aviation, and tank battalions on the basis of one per company (battery, troop). When in combat, aid men remain with supported units; however, when the unit is not engaged, aid men should return to the control of the medical platoon (section). The continuous support of combat personnel by medical personnel is a major factor in maintaining morale of the fighting troops.

(b) Aid men perform the following:

1. Provide emergency medical care.
2. Return to duty those patients requiring no further treatment.
3. Direct ambulatory patients requiring further treatment to the company aid post or battalion aid station.
4. Arrange medical evacuation for litter patients.
5. Initiate field medical cards for sick, injured, and wounded patients.
6. When time permits, initiate and complete field medical cards for deceased personnel.

(c) The senior medical aid man will—

1. Screen, evaluate, and provide medical treatment for conditions within his capability and return to duty those patients requiring no further attention. Patients requiring additional treatment are evacuated to the aid station.
2. Operate a company aid post near the company command post. Patients evacuated to the company aid post remain at that location pending appropriate disposition.
3. Coordinate and direct the activities of supporting aid-evacuation teams operating in the company area.
4. Keep the company commander informed of the medical status in the company area.
5. Report matters detrimental to the health of the command to the platoon or company commander and the battalion surgeon.
6. Supervise hygiene, sanitation, and the selection, treatment, and handling of water for consumption. The senior medical aid man may serve as a member of the unit field sanitation team.

(3) *Aid station element.*

(a) The first medical facility in the system of evacuation is the battalion (squadron) aid station operated by the aid station element of the medical platoon (section). An aid station cannot operate in more than one location, but may be divided for movement in echelons.

(b) The aid station is established as far forward in the battalion (squadron) area as the tactical situation permits. The location of the aid station may be farther forward in the attack than in the defense. Considerations governing the location of the aid station include the following:

1. The battalion (squadron) tactical situation.
2. Expected areas of high casualty density.
3. Protection afforded by defilade.
4. Convergence of lines of drift.
5. Evacuation time and distance.
6. Concealment and cover.
7. Security.
8. Accessible evacuation routes to front and rear.
9. Avoidance of likely target areas such as bridges, fords, important road junctions, firing positions, and supply facilities.
10. Location of open areas suitable for landing helicopter ambulances.
11. Availability of communication means.

(c) At the aid station, patients requiring further evacuation to the rear are given additional emergency medical treatment and prepared for evacuation. Constant efforts are made to prevent unnecessary evacuation. Patients with minor wounds or illnesses are treated and returned to duty as soon as possible. Other functions of the battalion aid station include—

1. Receiving and recording patients.
2. Monitoring personnel, when necessary, for radiological contamination prior to medical treatment.
3. Decontaminating and treating chemical casualties.
4. Notifying the battalion or squadron S1 of all patients processed through the aid station, giving identification and disposition as directed by unit SOP.

tion as directed by unit SOP.

5. Preparing field medical cards as required.

6. Verifying information contained on all field medical cards of patients evacuated to the aid station.

(d) Evacuation from the aid station is normally performed by the division medical battalion.

(e) Since no patient shelter or mess capability is provided, the holding policy of the battalion aid station is normally determined in hours rather than days. Only those procedures necessary to preserve life or limb, or those that enable a patient to be moved more safely are performed in an aid station.

(f) Unless contrary to division policy, ammunition and individual weapons are collected from patients at battalion aid stations, and disposed as directed by the battalion (squadron) S4.

(g) Patients evacuated to the rear retain individual equipment as prescribed by the division SOP. All excess equipment is collected at the aid station and disposed as directed by the battalion (squadron) S4.

(h) Patients requiring dental treatment are evacuated through normal medical channels to the supporting medical company where expedient dental treatment is provided.

(i) Patients requiring optometric service report to the battalion aid station. For those patients requiring only routine replacement of spectacles, necessary information is obtained from the patient or from the patient's health record and forwarded through medical channels to the optometry section of the medical battalion headquarters. For other than routine replacement of spectacles, patients are evacuated through medical channels to the medical battalion headquarters and support company located in the division rear area and given the required optometric service.

(4) *Evacuation element.*

(a) Evacuation in battalions or squadrons is dependent upon the number of ambulances assigned, the type division, type battalion or squadron, and the air ambulances available. The general principles, however, are to provide evacuation from platoon or company locations to the battalion or squadron aid stations.

(b) The operation of evacuation elements varies. Evacuation teams may—

1. Operate as far forward as the tactical situation permits and frequently find and treat patients who have not been seen by the platoon aid man. Aid-evacuation teams serve in direct support of companies, but remain under the control of the medical platoon or section.

2. Use one aid-evacuation team in a company area to evacuate patients to the company aid post. A separate aid-evacuation team may then be used for movement of patients from the company aid post to the battalion aid station.

3. Dismount, leaving vehicles at the company aid post, and form litter teams. Non-medical soldiers may be used to augment litterbearer teams providing the tactical commander has approved this measure.

(c) Specific duties of the evacuation section include—

1. Maintaining contact with combat elements.

2. Evacuating litter patients to the

battalion aid station.

3. Administering emergency medical treatment as needed.

4. Directing or guiding ambulatory patients to the aid station.

5. Assisting in movement of the battalion aid station.

6. Acting as messengers in medical channels.

7. Initiating or completing field medical cards as indicated.

(5) *Reinforcement.* Medical requirements must be considered when augmentation of the battalion (squadron) is planned. Reinforcement of the medical service from sources within the division may be necessary. Sources of reinforcement may be nonmedical troops of the division, divisional or nondivisional medical units, and subject to the provisions of the 1949 Geneva Convention, civilian labor units, and prisoners of war.

2-7. Medical Platoon, Infantry Battalion

a. *Organization.* The medical platoon of infantry battalions is shown in figure 2-1.

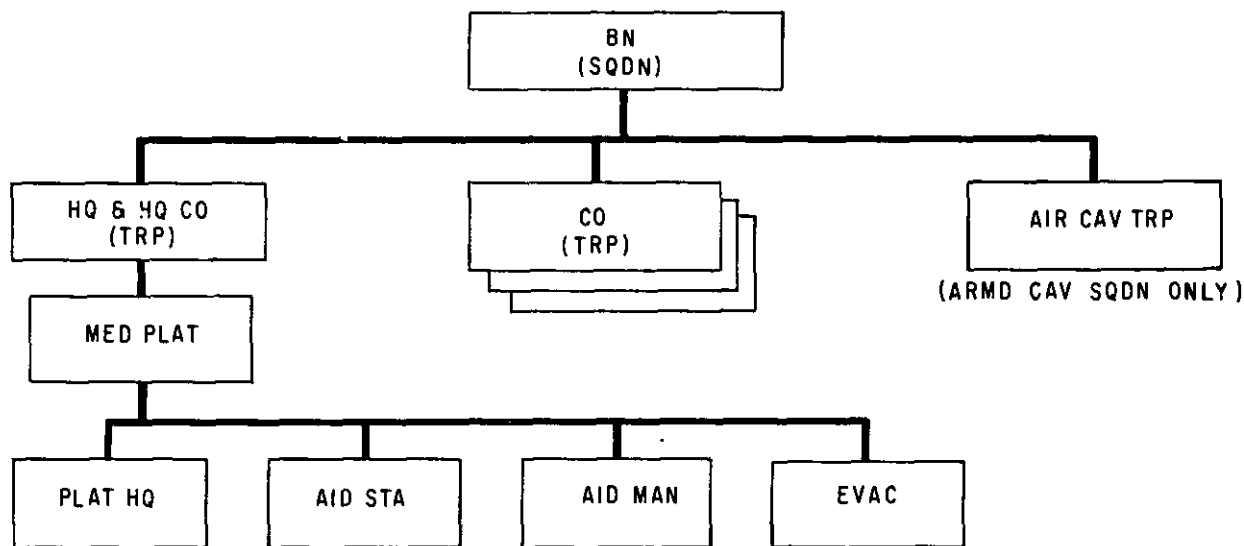


Figure 2-1. Infantry, infantry (mechanized), airborne infantry battalion, airmobile infantry battalion, tank battalion, and armored cavalry squadron.

b. *Employment.* The general scheme of employment as discussed in paragraph 2-6d and FM 7-20 applies. In addition—

- (1) Evacuation teams, using frontline

ambulances, are employed to best support the tactical plan. In normal employment, the following principles may apply—

(a) Two teams are usually placed in direct support of each committed rifle company. Wherever possible, these teams support a single company in order to familiarize members with the terrain and tactical situation. Evacuation from platoons is normally to the company aid post. Evacuation teams remain at the aid post when not evacuating patients in order that their activities can be controlled by the senior company aid man.

(b) Evacuation teams not in support of specific companies are retained at the battalion aid station to reinforce the evacuation team committed to the companies and to support the reserve when necessary. If used in a general support role, the teams evacuate patients from company aid posts to battalion aid stations.

(2) In the mechanized infantry battalion, three of the evacuation teams are mounted in frontline ambulances, and three in armored personnel carrier ambulances. The carriers permit the platoon to support mechanized rifle companies with evacuation teams that have the same mobility and armor protection as the supported company. The personnel carriers normally are used in direct support of committed companies to evacuate patients to predetermined collecting points. Patients may then be transferred to frontline ambulances and evacuated to the battalion aid station.

(3) In airborne infantry battalions, the medical platoon will deploy with the parent battalion, and will arrive in the assigned airhead by parachute or airlanded means.

2-8. Medical Platoon, Airmobile Infantry Battalion

a. General.

(1) The medical service in an airmobile infantry battalion, airmobile division, is similar to medical service of infantry battalions of other divisions, except that the aid station and evacuation elements are combined (FM 7-20).

(2) In the airmobile division, unit level medical service must be considerably more flexible because of a dependence on an air line of communication (ALOC) for patient evacuation. The battalion medical platoon must be capable of operating on either a centralized or decentralized basis. The operation may require

that units be deployed in an independent and completely isolated environment since ground lines of communication may not exist. Commitment of units under these conditions may require increased medical treatment and holding capabilities and air evacuation. When complete reliance on an ALOC is indicated, medical aid men at platoon and company level, company aid posts, and battalion aid stations must be prepared to care for patients until air ambulances or other aircraft arrive. Such care may involve moving patients to a secure area and providing protection from the elements.

b. Platoon Headquarters. The platoon headquarters is organized as discussed in paragraph 2-6b.

c. Aid Man Section.

(1) In an airmobile infantry battalion, company aid men may have an increased responsibility for sorting patients and indicating the evacuation destination. This responsibility arises with isolated small unit operations, where there may be no readily available ground means of evacuation. The aid man may recommend the battalion aid station as the proper treatment level for lightly wounded patients. Seriously wounded patients may be routed to a clearing station or supporting hospital. Treatment levels recommended by company aid men may be changed by commanders of air ambulances or other aircraft. This change may result from a re-evaluation of the patient, location of treatment stations or hospitals, and instructions from the command element or other requirements.

(2) Litter teams, when available, will be employed to bring patients to the helicopter loading points. Combat troops may assist when tactical conditions permit; however, the use of combat troops as litterbearers may detract from, or jeopardize, the unit's mission. Patient evacuation from helicopter loading points may be delayed pending aircraft availability, area security, and stabilization of action. Additional information on the functions of the aid man is contained in paragraph 2-6d.

d. Aid Station and Evacuation Section.

(1) The operation of the battalion aid station is generally the same as in other infantry battalions. In some cases, battalion aid stations need not be established in battalion

bases, and may be established in brigade areas in conjunction with the supporting medical companies. Although the role of the battalion aid station and clearing station in the normal chain of evacuation may be reduced by forward aeromedical evacuation, the need and use of unit and division level medical service are not reduced.

(2) The infantry battalion in an air-mobile division has no organic ambulances. The evacuation element of the aid station-evacuation section may provide litterbearer teams or use the backhaul capability of light weapons carrier (Mules) of the battalion headquarters and headquarters company. When the ground lines of communication between the companies and the battalion aid station are secure, the lightly wounded may be evacuated to the battalion aid station by litterbearers or vehicles. Otherwise, helicopter evacuation is required.

2-9. Medical Platoon, Tank Battalion

a. Organization. The battalion medical platoon is organized as shown in figure 2-1.

b. Employment. In addition to the general scheme of employment discussed in paragraph 2-6d and FM 17-1, the following apply to the employment of the tank battalion medical platoon:

(1) The medical platoon of a tank battalion is mobile and equipped to support over an extended area. In the tank battalion evacuation means and company aid service have been combined. In combat, medical aid-evacuation teams are attached to tank companies on the basis of one aid man and one aid-evacuation team per company. The remaining medical aid-evacuation teams may be used for the following:

(a) Reinforcement of medical support to a tank company.

(b) Evacuation of patients from an intermediate collecting point.

(c) Retention at the battalion aid station for use when required.

(2) Medical aid-evacuation teams closely follow the supported tank companies. When casualties occur within a tank, the aid-evacuation team, assisted by the tank crew, removes the patient from the tank and administers emergency medical treatment. Under heavy fire, self-aid or first aid performed by the surviv-

ing members of the tank crew must suffice until evacuation teams arrive. Patients may be evacuated to the battalion aid station by the medical aid-evacuation team. In a rapidly-moving situation, an injured member of a tank crew may remain in the tank until he is evacuated to a predesignated collecting point along the route of advance. APC ambulances, organic to the tank battalion medical platoon, are used for evacuating patients under conditions unsafe for frontline ambulances. The company aid man normally remains near the company command post, but may be used elsewhere. The aid man can be used to direct the aid-evacuation team to locations where patients have been left by tank crews.

(3) In the armored and infantry (mechanized) divisions, patient evacuation from collecting points to battalion aid stations, clearing stations, or mobile army surgical hospitals (MASH) may be solely by air. This is desirable in fast-moving situations when the movement of armor and mechanized battalions is not impeded. Air evacuation may be more practical for relieving tank crews and aid stations of caring for sick, wounded, or injured patients.

2-10. Medical Platoon, Armored Cavalry Squadron

a. Organization. The medical platoon is functionally organized as shown in figure 2-1. The medical service of the armored cavalry squadron of an airborne division is essentially the same as that of the armored cavalry squadrons of infantry, armored, and mechanized infantry divisions, except that it has fewer personnel and ambulances.

b. Employment. Medical support in the armored cavalry squadron is similar to that provided tank battalions (para 2-9 and FM 17-1).

(1) The normal method of providing medical support to an armored cavalry squadron is to place two evacuation teams and three aid men in support of each armored cavalry troop. Cavalry operations often prevent immediate treatment and evacuation; therefore, an injured or wounded member may receive first aid from another member of the crew and remain in the tank or other vehicle until placed

in a predesignated location for evacuation to the squadron aid station.

(2) Medical support for the air cavalry troop is provided by troop aid men from the medical platoon of the armored cavalry squadron who deploy with designated platoons. Casualties that occur when the troop is airborne will be evacuated directly to an aid station, division clearing station, or hospital. Casualties occurring while the troop is engaged in ground operations are treated by platoon aid men and evacuated to the nearest aid station upon return from operational areas.

(3) For evacuation purposes, the armored cavalry squadron of the armored, infantry, and mechanized division has both armored personnel carriers and frontline ambulances. The armored cavalry squadron of the airborne division has only frontline ambulances.

2-11. Medical Section, Air Cavalry Squadron, Airmobile Division

a. *Organization.* The battalion medical section consists of a headquarters and aid station, evacuation, and aid man elements (figure 2-2).

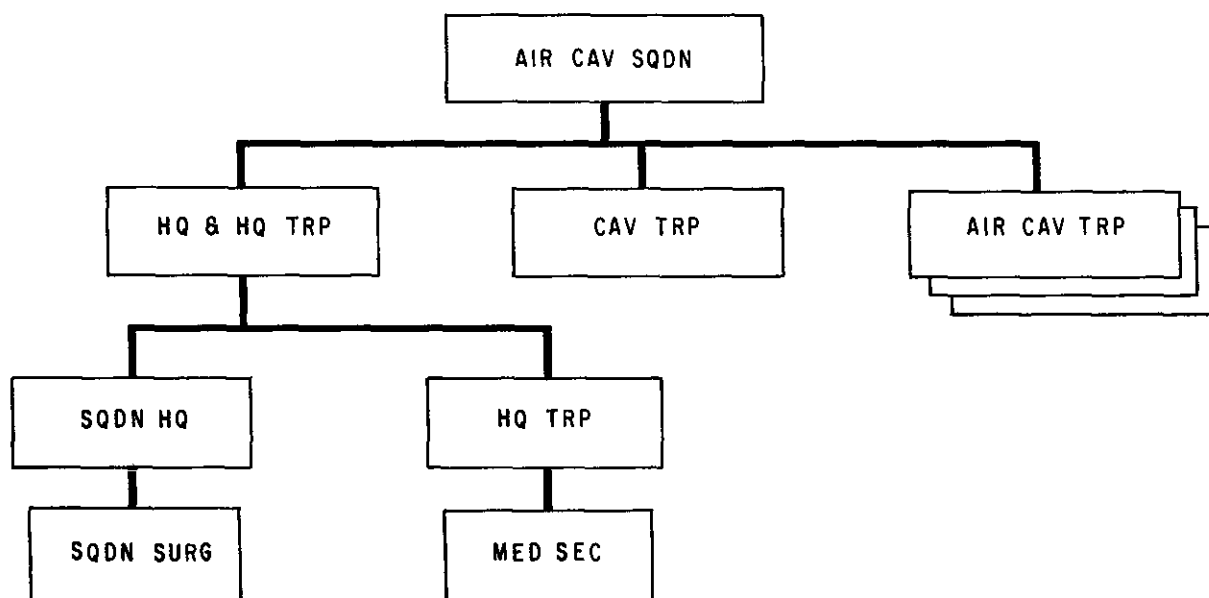


Figure 2-2. Air cavalry squadron, airmobile division.

b. *Employment.* In addition to the general scheme of employment discussed in paragraph 2-6d and FM 17-36, the following apply:

(1) Medical aid men are attached to the air cavalry troop on the basis of one per troop. The air cavalry troop aid man is normally located at the troop command post and provides emergency medical treatment to personnel of the troop. When the troop is airborne and casualties occur, they are taken by troop aircraft to the nearest medical facility as soon as the mission and tactical situation permit. Casualties occurring in ground operations are treated by troop aid men and evacuated to the squadron aid station.

(2) Medical service for the cavalry troop

is as described in paragraph 2-10.

2-12. Medical Section, Aviation Battalions

a. *Organization.* The battalion medical section may be functionally organized as shown in figure 2-3.

b. *Employment.* In addition to the general scheme of employment (FM 1-15), the following are applicable to aviation battalions:

(1) During combat operations, wounded crewmen are flown in organic aircraft to the battalion aid station or a division clearing station. Sick, injured, or wounded members of the battalion may be taken to the battalion aid station in the medical section's ambulance, or evacuated by other means.

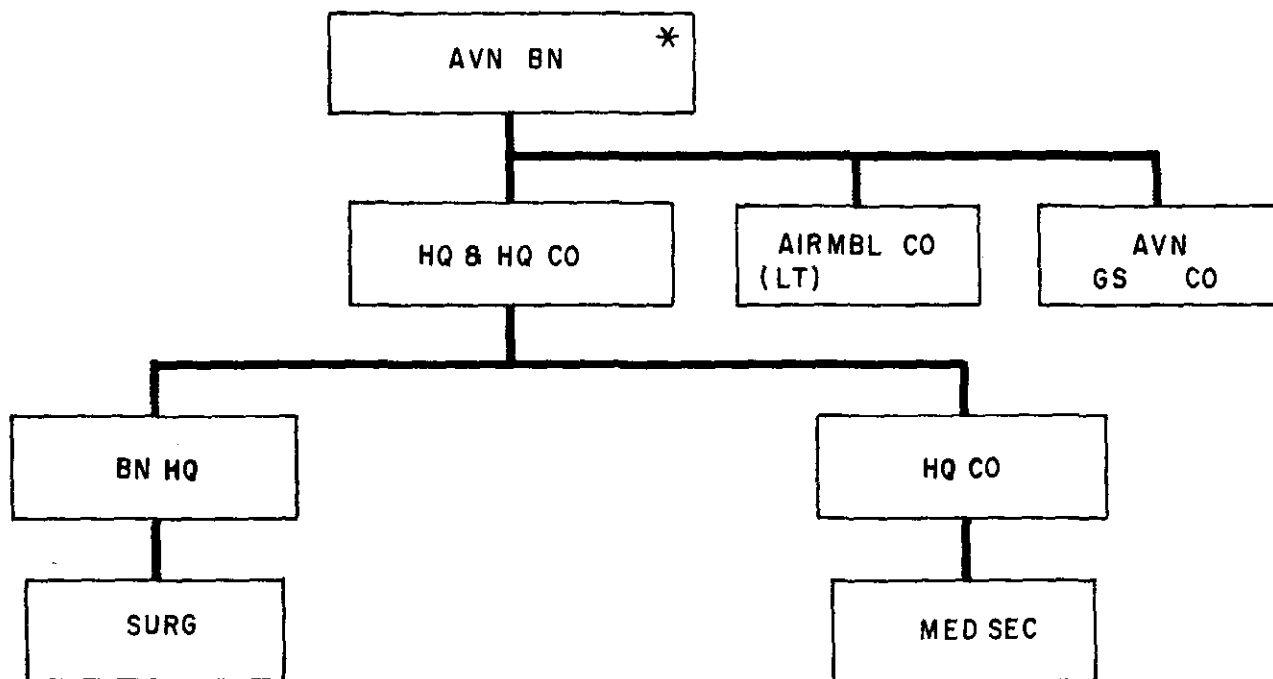


Figure 2-3. Aviation battalion.

(2) Casualties occurring aboard an aircraft while in transit to landing zones are given first aid by a crewmember. Casualties remain in the aircraft, and are evacuated to the nearest medical facility after completion of the mission.

(3) All aviation units have a capability of augmenting air ambulances. Nonmedical aircraft of the battalion may be called upon for assistance in moving patients on return flights of resupply and other missions.

2-13. Medical Section, Division Artillery

a. Organization. The division artillery medical section is organized into one section, but may be functionally organized as shown in figure 2-4.

b. Employment. Medical service for the division artillery headquarters is essentially the same as other unit level medical services. The medical section establishes an aid station near the division artillery command post and provides emergency medical treatment to personnel of the headquarters and headquarters battery. Aid men are employed only in the battalion aid station.

2-14. Medical Section, Artillery Battalions

a. Organization. The battalion medical section is organized into one section, but contains all the functional elements previously described. The division artillery organizations are shown in figure 2-5 and the medical support in figure 2-4.

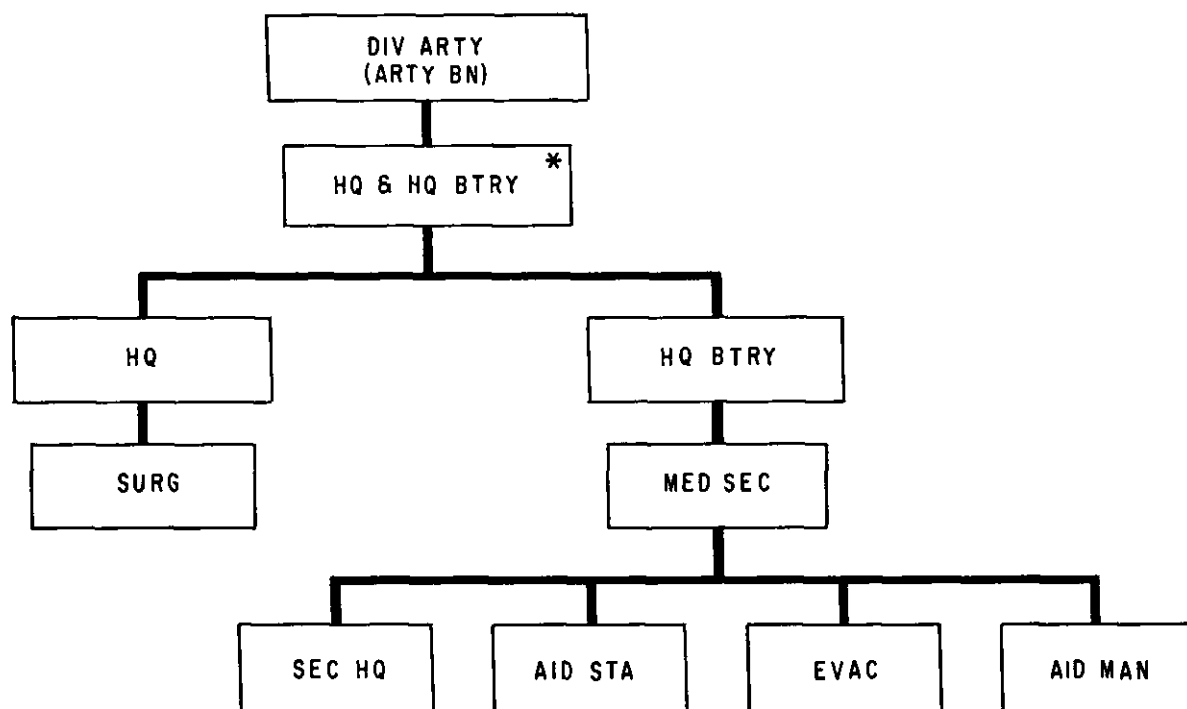
b. Employment.

(1) The general scheme of employment as discussed in paragraph 2-6 and FM 6-140 and the following apply to the employment of medical sections of artillery battalions.

(a) Normally, one battery aid man is provided to support each firing battery. The aid man provides emergency medical treatment to members of the battery.

(b) The evacuation element evacuates patients to the battalion aid station. Evacuation from the aid station may be by use of the same ambulance, unless assistance is requested from the supporting medical company of the division medical battalion.

(c) Medical service in the Honest John field artillery battalions follows the same general pattern; however, the two firing batteries



** HEADQUARTERS, HEADQUARTERS AND SERVICE BATTERY IN ARTILLERY BATTALIONS*

Figure 2-4. Medical section, division artillery, and field artillery battalions.

may be widely separated from each other and from the battalion headquarters. One organic ambulance may not be sufficient when there are casualties at multiple locations. Evacuation requirements exceeding the organic capability are referred to the supporting element of the division medical battalion.

(2) The following deviations exist in the employment of medical sections in artillery battalions of the airmobile division.

(a) Except for the aerial artillery battalion, the other battalions of the airmobile division do not have ground ambulances. The other artillery battalions of the division receive ambulance support from the division medical battalion. When artillery batteries are dispersed in support of airmobile operations, evacuation of patients is usually performed by the division medical battalion to the supporting medical treatment station. Evacuation of patients from battalion aid stations is provided

by air ambulances of the division medical battalion.

(b) Medical service in the field artillery battalion, aerial artillery, is somewhat different from the conventional field artillery battalions in that each battery is provided a battery aid man to establish a battery aid post. Patients may be taken to the battery aid post, battalion aid station, or division clearing station in organic aircraft or supporting air ambulances.

(c) Medical service of the division artillery aviation battery is provided by the medical section, division artillery headquarters.

2-15. Medical Section, Air Defense Artillery Battalions

a. *Organization.* The battalion medical section is organized into one section, but contains all functional elements as shown in figure 2-6.

b. *Employment.* In addition to the general scheme of employment discussed in paragraph

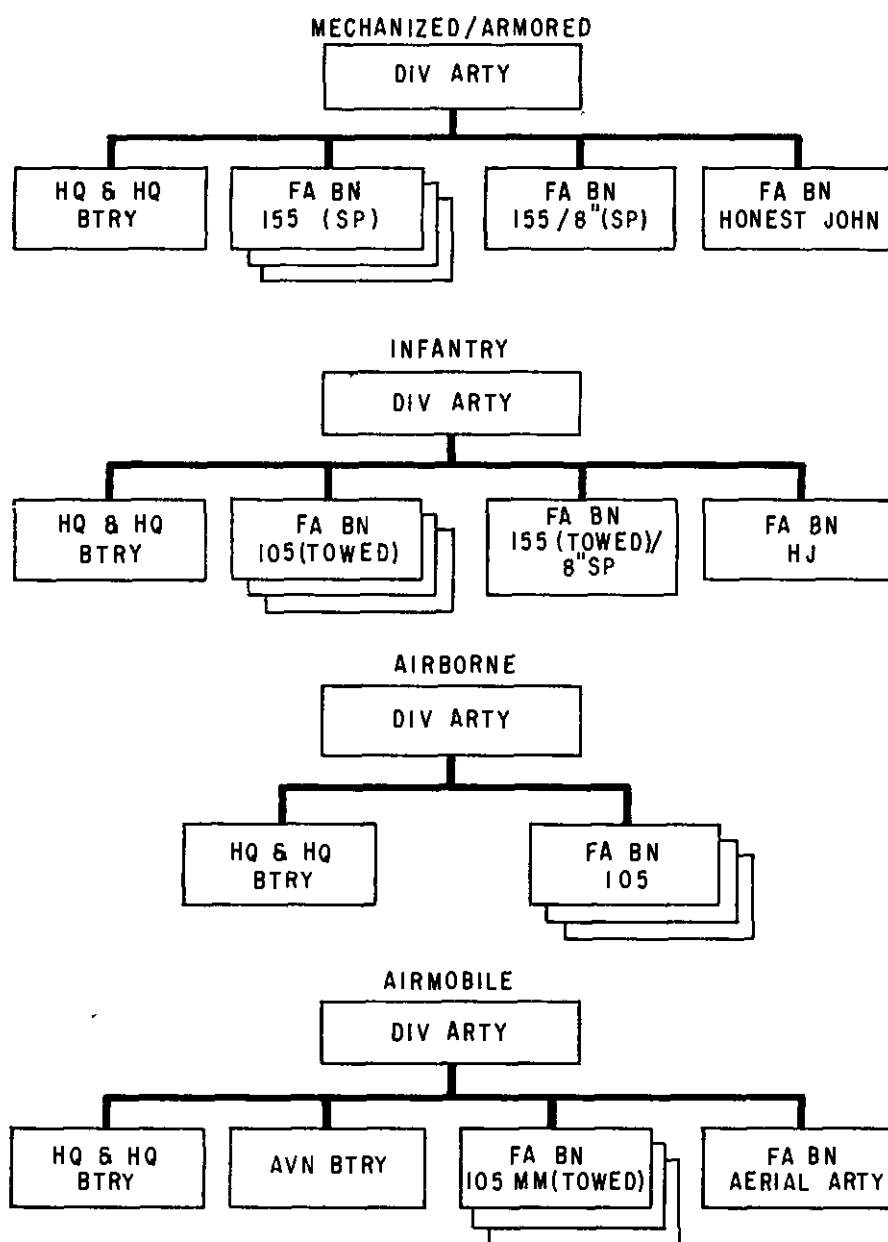


Figure 2-5. Division artillery battalions.

2-6, the following apply to medical service of air defense artillery battalions:

(1) The medical section provides two battery aid men to each firing battery, and one ambulance, with driver, to evacuate patients from battery locations to the battalion aid station.

(2) In the event firing batteries, platoons, or sections are assigned separate missions, a

realignment of battery aid men may be required. When batteries, or portions thereof, are operating in brigade areas, medical service, other than that given by battery aid men, is provided by the nearest supporting medical unit.

(3) Evacuation of patients to clearing stations is provided by ambulances of the nearest medical company.

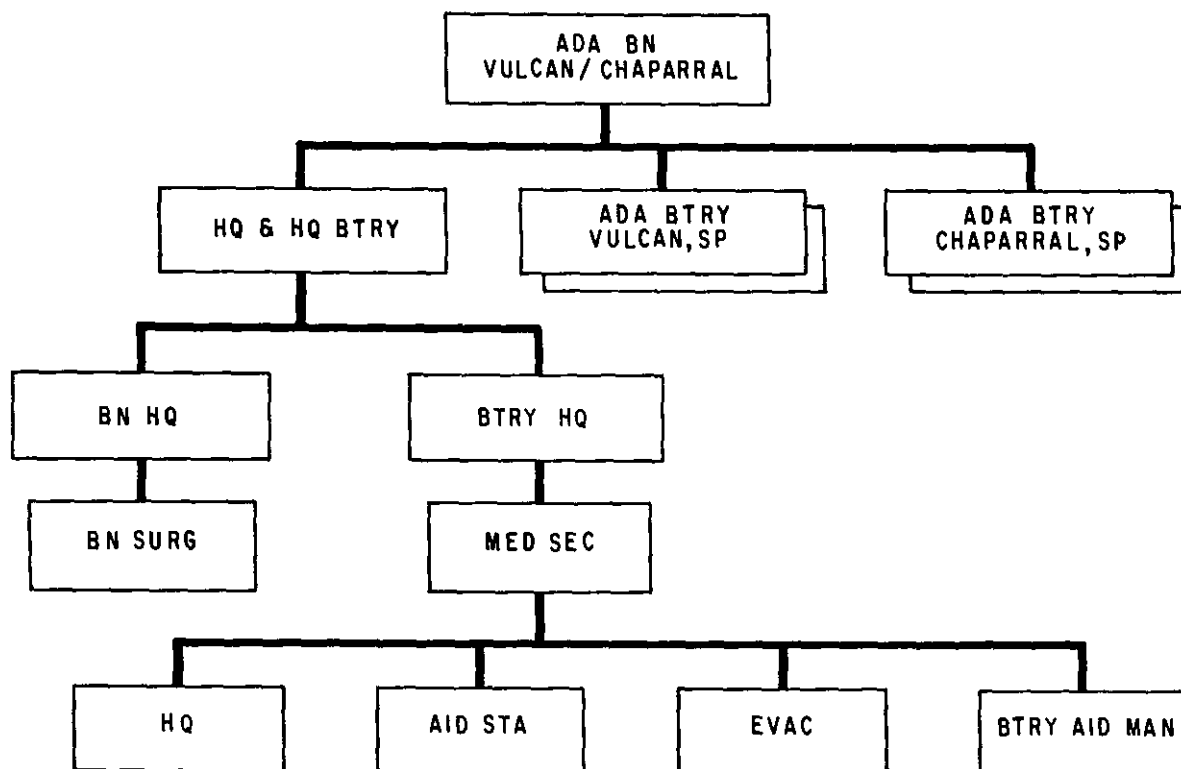


Figure 2-6. Air defense artillery battalion vulcan/chaparral.

2-16. Medical Section, Engineer Battalions

a. *Organization.* The battalion medical section (FM 5-135, FM 5-136) is organized into one section, but may be functionally organized as shown in figure 2-7.

b. *Employment.*

(1) Company aid men normally are located with supported companies and provide emergency medical treatment to company personnel. When the platoons are employed separately, additional company aid men from the medical platoon of the engineer battalion may be required. A company aid man normally accompanies the atomic demolitions team.

(2) Only one ambulance is available in the battalion.

(3) The engineer battalion can be employed as an infantry unit. When this occurs, the battalion medical section must be reinforced by the medical battalion with additional aid men, ambulances, and equipment to make it comparable to the medical platoon of a combat infantry battalion.

(4) Engineer companies frequently are

attached or placed in direct support of brigades. In either case, companies employed in brigade areas use their aid men for initial treatment and are provided unit and division level medical services by the supporting medical company of the division medical battalion.

2-17. Medical Section, Division Headquarters and Headquarters Company

a. *Organization.* The medical section may be functionally organized as shown in figure 2-8.

b. *Employment.*

(1) The section operates the division headquarters aid station and furnishes unit level medical service to division headquarters and elements of the signal battalion, military police company, and other units located near the division headquarters. The section also furnishes aid men to the signal battalion and military police company when required.

(2) Division level medical service, including evacuation of the aid station, is furnished by the division medical battalion.

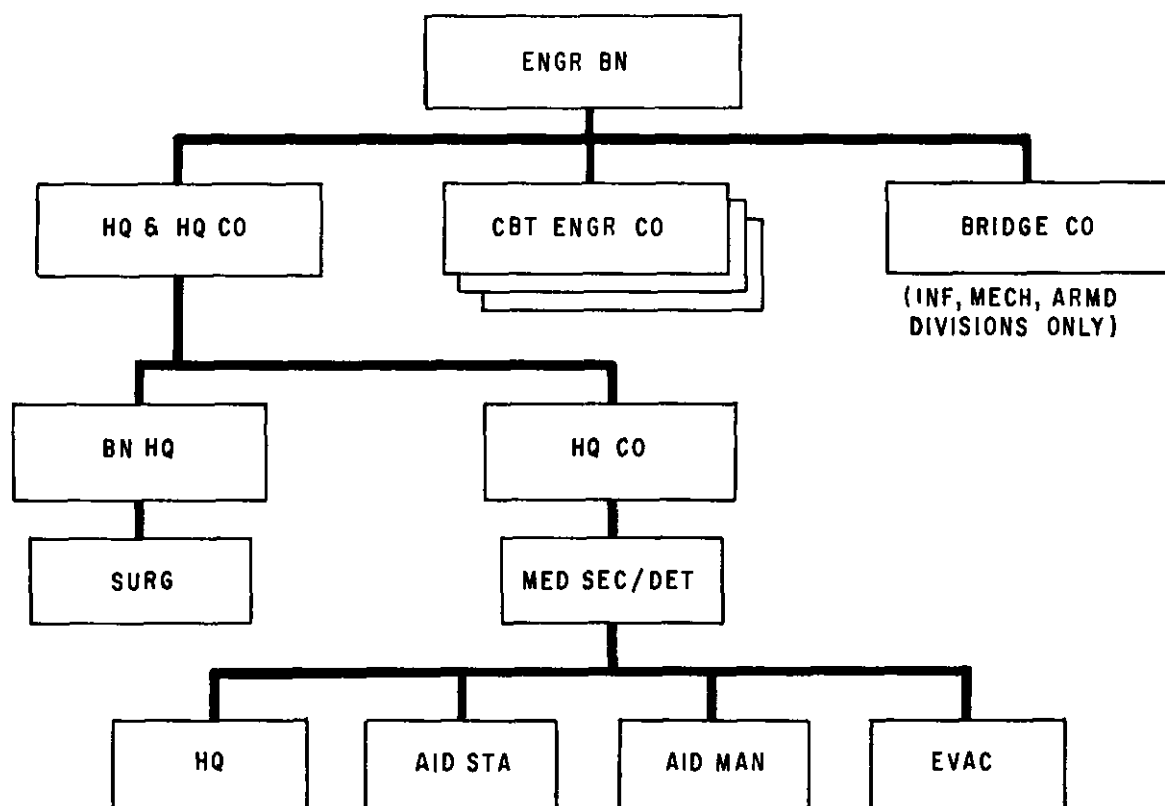


Figure 2-7. Engineer battalions.

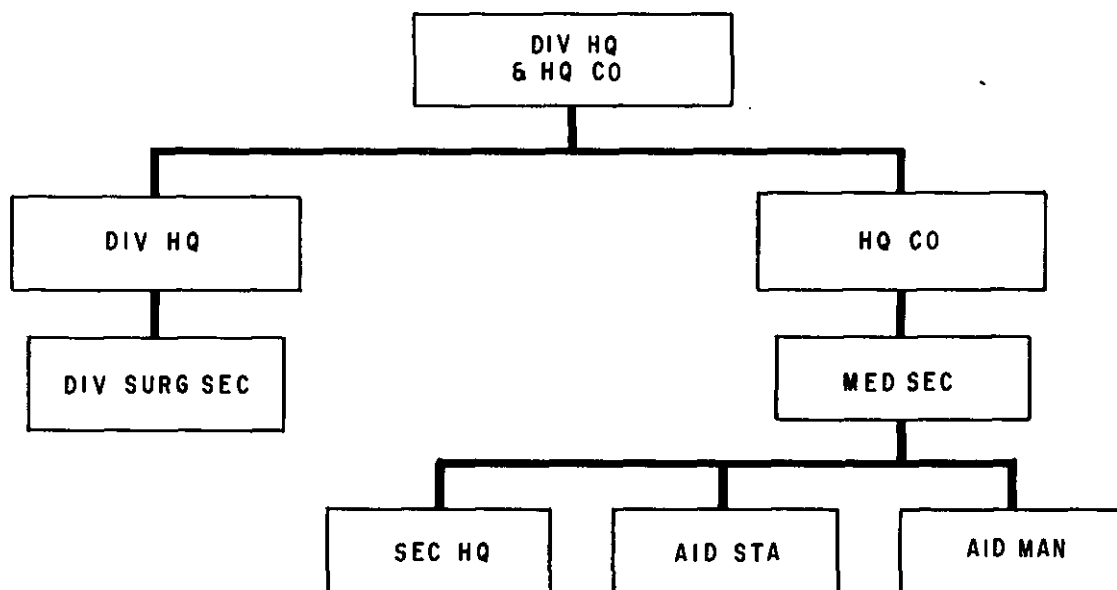


Figure 2-8. Medical section, division headquarters and headquarters company.

Section III. DIVISION LEVEL MEDICAL SERVICE

2-18. Medical Battalion, Infantry, Armored, Infantry (Mechanized), and Airborne Division

a. Mission and Functions. The division medical battalion provides division level medical services for all assigned and attached elements of the division. The division medical battalion—

- (1) Operates division clearing stations with a limited short-term holding capacity.
- (2) Evacuates patients from unit level medical treatment facilities.
- (3) Provides division-wide medical supply and organizational maintenance of medical

equipment.

(4) Provides expedient dental treatment, psychiatric service, and optometry service.

b. Organization. The division medical battalion, an element of the division support command, consists of a headquarters and support company and three identical medical companies (fig. 2-9). The medical battalions of the infantry, armored, and infantry (mechanized) divisions are identical. The medical battalion of the airborne division has less personnel and equipment. The medical battalion of the air-mobile division differs significantly and is discussed in paragraph 2-20.

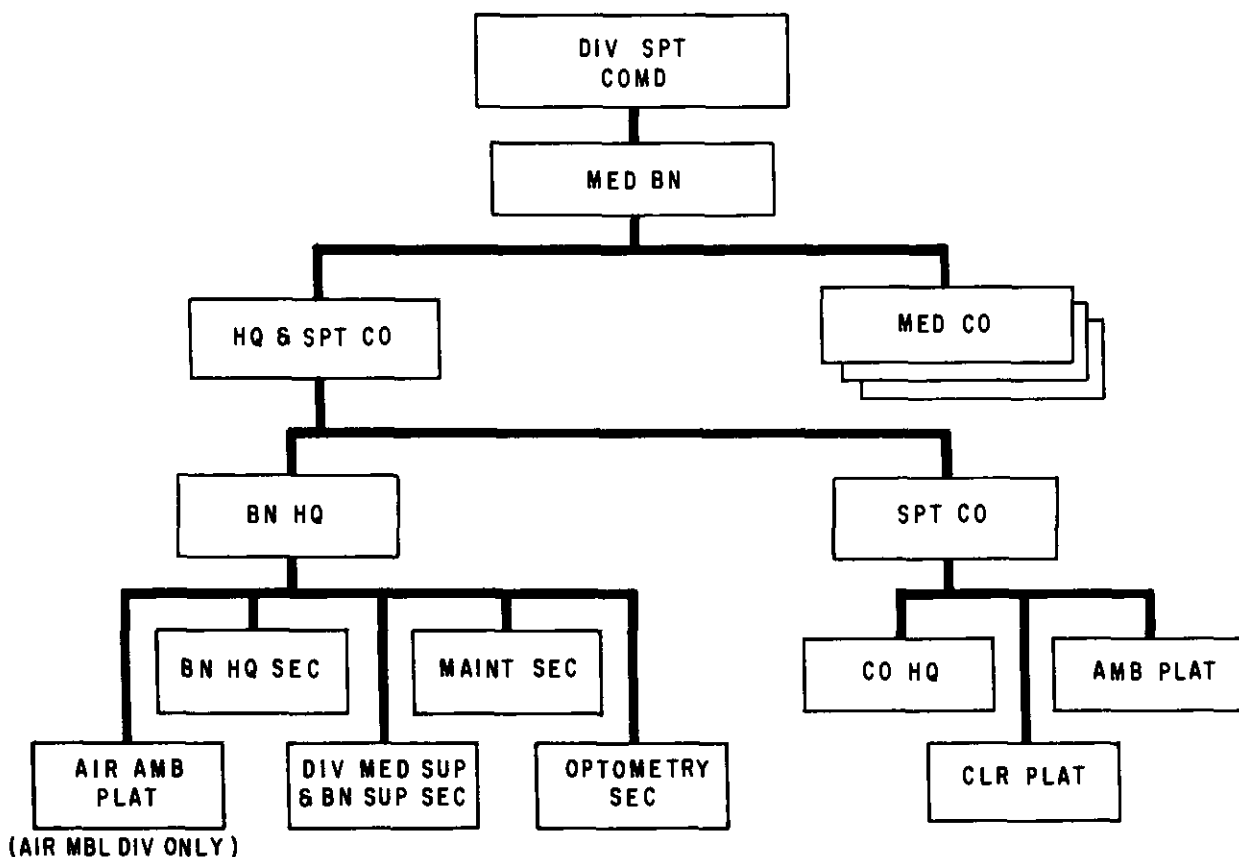


Figure 2-9. Medical battalion.

c. Employment. The three medical companies of the battalion normally are placed in support of the combat brigades, and establish

clearing stations in the brigade trains area, with the ambulance platoons evacuating patients from the combat battalions. The head-

quarters and support company is located in the division rear area and provides unit and division level medical service for troops in the area. The support company may be employed as a medical company when required.

d. The Battalion Headquarters.

(1) *Mission.* Provide command, control, administrative and logistical support for the medical battalion and plan for its employment.

(2) *Command and staff responsibilities and functions.* Common and specific responsibilities and functions are as described in FM 101-5.

(a) *The battalion commander.* The battalion commander, a Medical Corps officer, commands and controls elements of the medical battalion except when elements are attached to other commands. Normally, the battalion commander commands nondivisional medical service units attached to the division. In addition, the battalion commander—

1. Prepares the implementing plan for division level medical service in consonance with the division medical plan.

2. Operates the division level medical service.

3. Implements the division preventive medicine program as it applies to the medical battalion and support command elements.

4. Conducts the preventive psychiatry program in the support command in coordination with the division psychiatrist, and provides treatment to psychiatric patients.

5. Is responsible for individual and unit training of the battalion.

6. Serves as the medical staff officer to the support command commander by providing advice and assistance on medical matters for which the medical battalion is responsible and in the determination of requirements for medical service support.

(b) *Executive officer.* The executive officer is the principal assistant and advisor to the battalion commander. Although his specific duties vary depending on the desires of the commander, he performs duties similar to those of the chief of staff at the general staff level. The executive officer is responsible for execution of staff tasks, the efficient and prompt response of the staff, and the coordi-

nated effort of staff members. He transmits the commander's decisions to staff sections and to subordinate units; keeps abreast of the current situation and plans for future operations; and acts for the commander in his absence. He is also prepared to assume command of the battalion at any time; however, when elements of the battalion are actively engaged in patient care, command of the battalion normally is delegated to the senior Medical Corps officer present in the battalion.

(c) *Personnel staff officer, S1.* The personnel staff officer is the principal staff assistant on personnel matters. These personnel matters include maintenance of unit strengths, personnel and manpower management, morale and welfare, headquarters management, and discipline, law, and order.

(d) *Operations and training officer, S3.* The operations officer, S3, is the principal staff assistant and has staff responsibility for—

1. Keeping all concerned informed on combat intelligence and counterintelligence; and collecting, evaluating, and interpreting information pertaining to the effect of weather, terrain, enemy, and civilian population on the medical battalion mission.

2. Developing plans, policies, programs, and procedures pertaining to the medical battalion operations and functions.

3. Organizing the medical battalion for medical support operations.

4. Planning and supervising the allocation of medical battalion units for specific missions.

5. Conducting inspections of medical battalion units, installations, and activities.

6. Planning and supervising the training of medical battalion units.

7. Planning, coordinating, and supervising medical support of civil affairs, psychological operations, unconventional warfare, and stability operations.

8. Planning and supervising medical support against chemical, biological, and nuclear attack, and against unconventional and psychological warfare operations. The operations officer prepares the medical plans for rear area security and area damage control.

9. Planning, supervising, and coordinating patient evacuation from units supported by division level medical units.

10. Planning, supervising, and conducting medical regulating duties when movement of patients between treatment units is necessary.

(e) *Supply staff officer, S4.* The supply officer, S4, has staff responsibility for—

1. Determining logistic requirements for the medical battalion.

2. Planning and supervising medical supply and maintenance functions provided by the medical battalion.

3. Issuing equipment and supplies to units of the medical battalion in accordance with the priorities recommended by the operations staff officer.

4. Recommending additions to, or deletions from, the controlled items list and establishing procedures for control of critical items.

5. Collecting and disposing of excess, salvage, and captured medical materiel.

(f) *Other staff advisors.* The division social work officer assists the battalion commander in carrying out the division plans for the management of psychiatric patients; provides professional supervision of the psychiatric personnel assigned to the battalion; and assists the division psychiatrist in planning, coordinating, and executing the division program for the prevention of psychiatric disorders.

(g) *Staff relationships.* The medical battalion commander and staff and the division surgeon normally employ direct channels of communication on professional or technical matters.

(3) *Division medical supply-battalion supply section.*

(a) *General.* The supply section operates under the staff supervision of the medical battalion S4 who is also the division medical supply officer (DMSO). The supply officer supervises and controls the medical supply support to all organic and attached medical units of the division as well as general supply support of the medical battalion.

(b) *Division medical supply element.* The medical supply officer supervises the divi-

sion medical supply personnel and is assisted by medical supply assistants and a pharmacy specialist. The section maintains a small reserve of medical supplies which are transported in organic vehicles.

(c) *Battalion supply element.* The battalion supply element is supervised by the battalion S4. Requests for expendable and nonexpendable supplies are submitted by each medical company directly to the battalion. The S4 then forwards requests to the appropriate supply point.

(4) *Optometry section.* The optometry section, under the supervision of an optometry officer, provides optometric service, including routine eye examination and refraction; resurfaced, single-vision, prescription spectacle fabrication; and spectacle repair services for units assigned or attached to the division.

(5) *Maintenance section.* A maintenance section, under the supervision of the motor officer, performs organizational maintenance in the battalion. In addition, the section performs organizational maintenance on division medical equipment.

e. *Headquarters and Support Company.*

(1) *Mission.* The mission of the headquarters and support company is to provide division level and unit level medical service to divisional units operating in division rear area.

(2) *Capabilities.* The capabilities of the headquarters and support company are to—

(a) Receive, sort, and provide temporary medical and surgical treatment for 80 patients and provide emergency medical treatment for a total of 120 patients for a limited period.

(b) Provide expedient dental treatment.

(c) Provide psychiatric treatment.

(d) Evacuate patients from supported unit aid stations.

(e) Provide unit level medical service on an area basis to divisional units having no organic medical element.

(f) Serve as a unit replacement, when necessary, for one of the medical companies supporting a brigade.

(3) *Organization.*

(a) *Support company headquarters.*

The company headquarters performs the command, administration, mess, vehicle maintenance, and supply functions for the company. The command element consists of a Medical Corps commander, a Medical Service Corps executive officer, and enlisted assistants.

(b) *Ambulance platoon.* An ambulance platoon with field ambulances provides local evacuation in the division rear area. The platoon is commanded by a platoon leader assisted by a platoon sergeant. Operating personnel include drivers and ambulance orderlies who assist as litterbearers when needed. Platoon personnel evacuate patients from supported units and aid stations to a division clearing station. The platoon provides in-transit medical treatment and care of patients during evacuation.

(c) *Clearing platoon.* A clearing platoon can operate one clearing station with a capacity of 80 patients. When the division has an abnormally high patient workload, the platoon can accommodate 120 patients for a limited period. The platoon may temporarily divide its resources in an echeloned displacement; however, two complete clearing stations cannot be operated simultaneously because of insufficient personnel and equipment. The clearing element provides expedient dental treatment; psychiatric treatment; resuscitative treatment to patients requiring further evacuation; and definitive treatment to patients who can be returned to duty. In the armored, infantry, and infantry (mechanized) divisions, the Medical Service Corps assistant plans and supervises tactical and administrative operations.

f. *Medical Company.* The medical companies of the battalion are equivalent to the support company in organization, capabilities, and resources (fig. 2-9). The medical battalion of an airborne division has fewer personnel in the medical companies than in the support company.

2-19. Medical Battalion Operations

a. Medical Supply and Equipment.

(1) Requisitions for medical supplies originating from medical elements of combat and combat support battalions are forwarded to the supporting clearing station by the most

expeditious means. Normally, the clearing station fills requisitions from the prescribed loads of medical stocks on hand and forwards the supplies by the fastest means available. Unfilled requests and requisitions to replenish clearing station stocks are forwarded to the division medical supply officer at the medical battalion headquarters.

(2) The division medical battalion maintains a prescribed load of medical supplies in a mobile supply point for use in emergencies or when delays are experienced in shipments to the division. Requisitions from supported units are filled from these stocks.

(3) The medical battalion places requisitions for medical supplies on the medical class VIII supply point established in the corps rear area by the medical brigade of the FASCOM. This supply point is operated by an advance medical depot. Medical supplies normally are delivered to the division medical battalion by field army transportation or by returning medical vehicles. In some instances, supplies may be received directly from medical depots further to the rear.

(4) The division medical supply officer is responsible for the stockage of medical supplies in the division medical supply point. Equipment and nonrecurring expendable supplies received from a medical supply depot are forwarded to medical unit supply officers. Medical unit supply officers are responsible for all property issued to their respective units.

(5) In noncombat situations, medical supply requisitions from subordinate elements of the division are submitted by each medical unit supply officer. The division medical supply officer consolidates and forwards requisitions as directed by local SOP and directives.

b. *Whole Blood Requirements.* When plans are formulated for tactical operations, whole blood requirements are forwarded through the division surgeon's office to the appropriate blood distribution element designated by the Army blood program officer. Once blood has been authorized for use within the division treatment stations, resupply is through the normal blood bank service channels using the most expeditious means of communication and transportation available.

c. Evacuation.

(1) *General.* The ambulance platoon of a division medical company provides ambulance service within its area of responsibility. The missions of the ambulance platoon are to—

(a) Evacuate patients and transport medical personnel and materiel as required.

(b) Transport messages and medical supplies from one medical unit to another along routes of evacuation.

(c) Provide emergency medical treatment and care for patients en route to a treatment station.

(2) *Ambulance plan.* The ambulance plan prepared by the ambulance platoon leader will include—

(a) The initial and alternate ambulance routes.

(b) The locations of the medical company command post and the ambulance relay, control, and loading posts when a shuttle system is used. Without a shuttle system, the plan should include ambulance locations and the medical evacuation system to be used.

(c) Provisions for relief and messing of ambulance platoon personnel.

d. Clearing. Patients are sorted at the clearing station. Those patients expected to return to duty within the established division evacuation policy are retained, and others are evacuated after any necessary resuscitative measures have been taken to insure their survival en route.

(1) *Employment.* Clearing platoons of the headquarters and support company and the medical companies are employed as follows:

(a) The combat brigades are provided division level medical support by medical companies of the division medical battalion. The clearing platoons of the medical companies establish clearing stations normally located in the brigade trains area. Support of brigades is maintained by moving the clearing stations as the brigades displace.

(b) The clearing platoon of the headquarters and support company establishes a clearing station in the division rear area and provides medical support to troops located there.

(c) A central psychiatric treatment facility is established under the staff supervision of the division psychiatrist for receiving, sorting, evaluating, and rehabilitating psychiatric patients. Such a facility may be located with one of the medical companies, but is normally with the headquarters and support company to provide division-wide services.

(2) *Selection of sites.* Sites for clearing stations in brigade areas are allocated by the brigade S4. In the division rear area this is done by the S4 of the support command. Within a designated area, the location of the station should be accessible to routes of evacuation and a helicopter landing area. Sites should be beyond the range of hostile light artillery. This may not be possible, however, in counterinsurgency warfare or operations including guerrilla rear area infiltrations. In these conditions, the clearing station may be dug in or sandbagged sufficiently to protect personnel and patients. Overhead cover sufficient to protect individual shelters from a direct hit may be desirable.

(3) *Protection.*

(a) All medical facilities are protected by the Geneva Convention. As a prerequisite to protection afforded by this agreement, facilities must be plainly marked. Medical facilities, may reveal the tactical dispositions of the division and the commander may deem their concealment necessary. No compromise must be made between these two considerations. The decision to deviate from markings and forfeiture of the protection related thereto must be made by the tactical commander.

(b) All-important in military operations is the precept that medical units are not organized as combat units. While the medical mission must always be the principal consideration, a balance must be maintained between providing both medical service and protection of medical personnel, patients, and medical facilities. All active and passive measures of defense, in keeping with treaties and customary international law, must be taken by the Army Medical Service personnel. By simple definition, all signatory parties to the aforementioned treaties and conventions have a

mutual obligation—that of not attacking by fire, or other physical means, medical personnel, patients, or facilities. The medical service has the paralleling responsibility for not provoking or creating situations, in violation of international law, that could cause these attacks.

(c) Medical units usually are located within the area of the supported tactical unit. The supported unit S3 has staff responsibility for rear area security. In addition, he develops security measures for the area, and coordinates and integrates local defense plans of individual units with the overall rear area security defense plan. These plans, however, should not require medical units to fire on attacking troops until it becomes imperative as a result of direct attack upon the medical units. Medical units should not fire to support adjacent units unless the medical unit is directly threatened as a separate and distinct portion of the overall defensive position.

(4) *Operations.* The majority of patients are received from the aid stations of supported units.

(a) Patients arrive irregularly and often may exceed the station's resources. In an attempt to give prompt attention to each patient, careful sorting and standardization of procedures will facilitate evacuation of patients and the establishment of treatment priorities.

(b) Some patients will not be transportable for a time because of conditions such as shock or hemorrhage. These cases should be resuscitated prior to movement. When a patient is transportable, the nature of his injuries will determine how he is evacuated and the destination.

(c) Clearing stations receiving patients for admission or consultation must insure that ammunition, grenades, and personal weapons are collected from patients and disposed of as directed by the battalion (squadron) S4.

(5) *Medical records.*

(a) An individual medical record (DD Form 1380 (U.S. Field Medical Card)), prepared by an aid man or by personnel of an aid station, should accompany each patient evacuated to the clearing station. In the event a pa-

tient arrives without a field medical card, one will be prepared at the clearing station indicating that station as the place of direct admission. Individual medical records on all completed cases (patients disposed of by any manner other than by transfer to another Army medical treatment facility and patients carded for record only) will be retained and forwarded as required by the division surgeon (AR 40-400).

(b) A field medical card reflecting treatment and disposition will accompany all patients evacuated from the clearing station.

(c) Reports required by AR 40-417 will be prepared at the clearing station and forwarded as required by the division surgeon.

(6) *Disposition of patients.*

(a) Patients in clearing stations are evacuated to hospitals, treated until ready to return to duty, or returned directly to duty, depending on their medical need. An exception is made in the evacuation of psychiatric patients. Their disposition is at the direction of policies established by the division psychiatrist—usually to a central psychiatric facility.

(b) Personnel being returned to duty are reported to their organization. The individual's parent unit provides transportation. Discharged patients will not be returned to their unit in vehicles carrying the Red Cross markings.

(c) Allied patients who are treated in U.S. medical facilities will be transferred to hospitals or other treatment elements of their own national organization in accordance with STANAG 2061 and STANAG 2075 (app B).

(7) *Evacuation from clearing stations.* The evacuation of patients from clearing stations is a function of the field army medical service. A supporting separate medical battalion or medical group of the field army medical brigade makes evacuation arrangements in coordination and compliance with the division surgeon's requests or plans. These arrangements include emergency and routine provisions for an adequate number of ground and air ambulances.

e. Dental Service. Dental officers are assigned to the division medical companies and support the mission of these units. They provide treatment and, as appropriate, prepare

patients for further evacuation or for return to duty. The dental officers are capable of performing all expedient dental procedures necessary to return the majority of patients to duty. In addition, the dental officers conduct continuous programs of dental health education for the division troops.

2-20. Medical Battalion, Airmobile Division

a. General. The airmobile division reflects a shift in emphasis from the ground vehicle to the air vehicle. Within the division medical service, the principal result of this concept is a corresponding shift from ground to air evacuation. Evacuation by air becomes the rule rather than the exception. This function is performed by the division medical battalion. Another significant difference is that the clearing platoons of the medical companies and the support company have an expanded medical treatment capability. These differences are discussed below.

b. Mission and Functions. The mission and functions of the medical battalion, airmobile division, are as described in paragraph 2-18a.

c. Organization. The division medical battalion, an element of the division support command, consists of a headquarters and support company and three identical medical companies.

d. Employment. The medical battalion is employed essentially as medical battalions of other divisions as discussed in paragraph 2-18c. Elements of the battalion normally are airlifted into brigade and division bases by aircraft of the aviation group. Air ambulances of the battalion may assist in the movement.

e. Headquarters and Support Company.

(1) *Mission.* The mission of the headquarters and support company is as described in paragraph 2-18e.

(2) *Capabilities.*

(a) The capabilities of the medical battalion headquarters section of headquarters and support company are as described in paragraph 2-18d, except as indicated below:

1. Performs organizational maintenance on aircraft, vehicles, and communications equipment of organic elements of the division medical battalion.

2. Provides division-wide aeromedical evacuation, in-flight treatment of patients,

and aerial delivery of whole blood, medical supplies, and medical personnel.

3. Performs division-wide air crash rescue support on an area basis.

(b) The capabilities of the support company are described in paragraph 2-18e, except that the clearing facility can provide medical and surgical treatment for only 60 patients. In emergencies, the clearing platoon can expand its facilities to accommodate 100 patients for a limited period.

(3) *Organization.*

(a) The organization of the headquarters and support company, airmobile division, is basically the same as headquarters and support companies of other divisions discussed in paragraph 2-18e. Only the differences are covered in the following paragraphs.

(b) An air ambulance platoon is organic to the battalion headquarters, as shown in figure 2-10.

1. The platoon headquarters personnel perform all administrative tasks including planning, training, and supervising platoon operations. The base of operations of the platoon headquarters normally is near the medical battalion headquarters.

2. The air ambulance section provides aeromedical evacuation for the division elements.

3. The air crash rescue section is employed in the division area as required.

(c) The maintenance section has been expanded to include the capability to perform organizational maintenance of organic aircraft and aviation electronic equipment. In addition, a maintenance officer has been added to supervise the maintenance section and to advise the battalion commander on maintenance matters.

(d) The support company consists of a company headquarters, a clearing platoon, and an evacuation platoon.

1. The company headquarters is organized and functions as described in paragraph 2-18e.

2. The clearing platoon is similar to those found in other divisions, but is capable of caring for only 60 patients over an extended period. With an augmentation of cots, 40 additional patients can be accommodated for

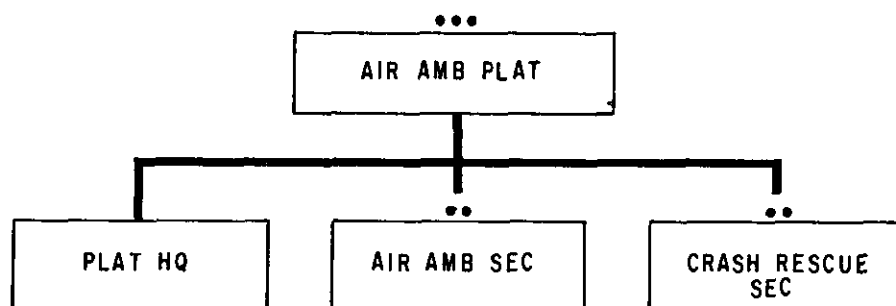


Figure 2-10. Ambulance platoon, airmobile division.

short periods. The emergency treatment and resuscitative capability of the platoon has been significantly increased with the assignment of additional surgeons, nurses, and operating room specialists. In addition, an X-ray machine and an enlisted technician have been added. Limited post-operational care of patients is available. The platoon cannot be divided into equal parts, but may be echeloned for movement.

3. The ambulance platoon evacuates patients to airfields for further evacuation to hospitals and also to evacuate patients from the aid stations of supported units. For this purpose, the ambulance platoon is equipped with frontline ambulances (FLA).

f. Medical Company.

(1) The three medical companies of the battalion are identical. Only minor organizational differences exist between the support company and the medical companies.

(2) The ambulance platoons are equipped with light weapons carriers (Mule), complete with litter kits. The platoon provides local patient evacuation from units within the brigade base and from air ambulances or other helicopters to the clearing station. When adequate and secure ground lines of communication exist, the platoon may evacuate patients from battalion aid stations to the clearing station. The platoon may also reinforce the evacuation capability of the medical platoon of an infantry battalion.

2-21. Airmobile Medical Battalion Operation

a. General. The medical battalion generally is employed in the same manner as the medical battalion in infantry, infantry (mecha-

nized), airborne, or armored divisions. The headquarters and support company normally is employed in the division support area of the division base of operations. Medical companies support each committed brigade and usually are located in the brigade bases operating under the control of a forward support operations officer who is a part of the support command forward support element. All units located in the brigade base are under the tactical control of the brigade.

b. Medical Supply. The medical supply function in the airmobile division is similar to that of other divisions. Occasionally, however, the distribution of medical supplies will be by Army aircraft, directly from the FASCOM advance medical depot, to the brigade or division airfields, and then to the appropriate medical company. Distribution from the medical company to the battalion aid station normally is made by the air ambulance platoon of the medical battalion.

c. Clearing. The clearing functions of patient sorting and treatment are similar to that described in paragraph 2-18e. When the division is operating independently in a semi-isolated area, or when evacuation is not possible, patients will be given resuscitative treatment and retained in the clearing station until evacuation is provided.

d. Division Aeromedical Evacuation and Crash Rescue Service. The air ambulance platoon of the division medical battalion provides air ambulance and air crash rescue service for the division. The range of operations may extend from the line of contact, or into enemy held areas, to the division rear boundary. The medical battalion commander retains opera-

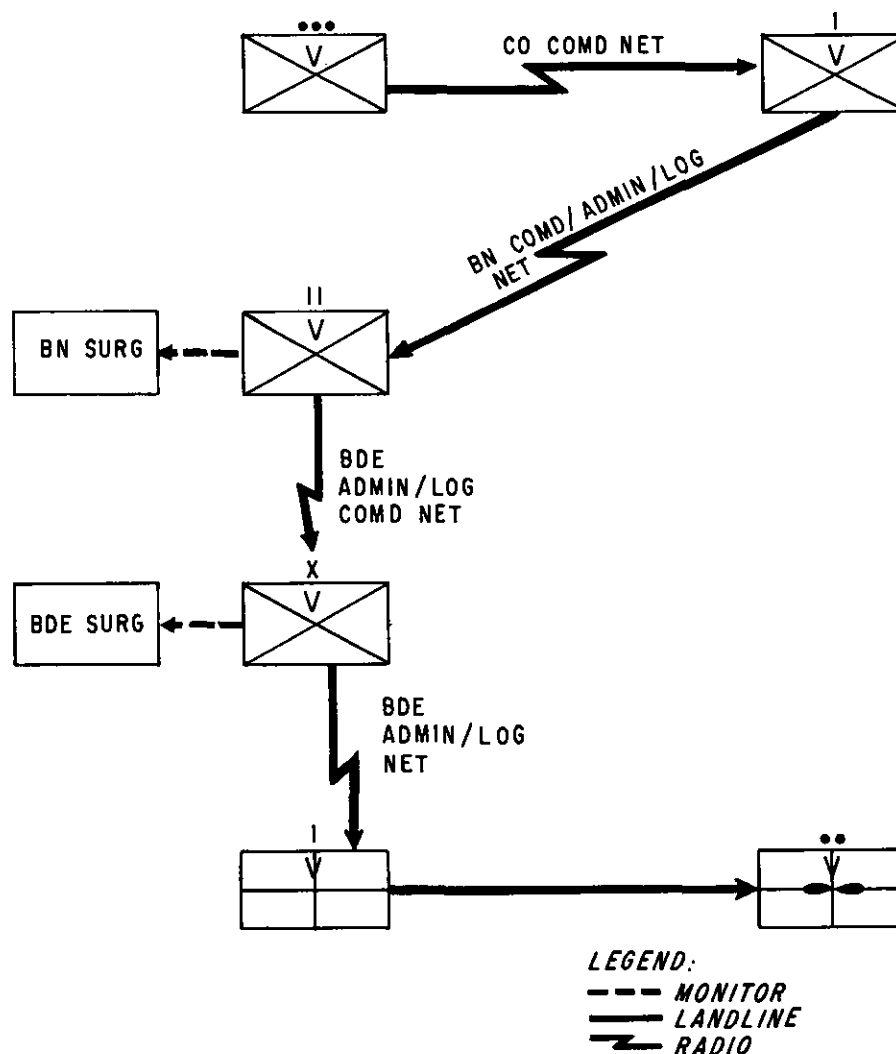


Figure 2-11. Communications channels for aeromedical evacuation requests.

tional control of the platoon, which includes detached elements when employed in support of infantry brigades. This provides the necessary flexibility of air ambulance resources to support the rapidly changing situations in air-mobile operations. The tactical situation may require that air ambulances be shifted from an area of low casualty density, to an area of heavy casualty density. However, to support isolated task force operations, elements of the air ambulance platoon may be attached to the task force.

(1) *Aeromedical evacuation.*

(a) The air ambulance element supporting a tactical brigade establishes its base

of operations adjacent to the medical company supporting the brigade. The air ambulance crew provides aeromedical evacuation service to the brigade as required. The unit receives evacuation requests from the medical company commander. During air assault operations, Army Medical Service aircraft normally will accompany assault helicopters to the landing zone and be immediately available to proceed to pickup sites and evacuate patients to a medical treatment facility.

(b) Requests for air ambulance evacuation originating at the infantry platoon level are processed as shown in figure 2-11. Requests made over the supported battalion ad-

ministrative net to the S4 are relayed over the brigade administrative net to the brigade S4 and relayed by wire or radio to the supporting medical company; and finally relayed to the air ambulance element. The infantry battalion and brigade surgeons may monitor the requests for aeromedical evacuation. Silence on the part of these surgeons indicates concurrence of request.

(2) *Air crash rescue.*

(a) One air crash rescue aircraft normally supports each committed brigade and receive mess, communications, and logistical

support from the medical company supporting the brigade. The air crash rescue aircraft remaining with the medical battalion headquarters provides support in the division base area. Air crash rescue aircraft should not be diverted from their primary mission.

(b) The air ambulance platoon leader usually retains operational control of the crash rescue aircraft. The crews and aircraft are centrally located within the assigned area of responsibility. In isolated brigade operations, a crash rescue section normally is attached to a medical company for mission support.

Section IV. MEDICAL SERVICE OF OTHER DIVISIONAL UNITS

2-22. Medical Service to the Signal Battalion

Elements of the signal battalion operate throughout the division area (FM 11-50 and FM 11-51). Medical service for these elements normally is provided by the nearest medical treatment facility. When operating in isolated areas, medical aid evacuation teams may be attached to signal elements. Normally, these teams are furnished by the medical battalion; however, the medical section of division headquarters and headquarters company may provide a team for a short period of time.

2-23. Medical Service to the Military Police Company

a. Elements of the military police company are employed in brigade areas, in the division rear area, and at PW collecting points. Medical service normally is provided by the nearest medical facility.

b. Wounded PWs in collecting points are

evacuated to the nearest medical facility. Guards for wounded, sick, or injured prisoners are furnished by the military police company. If military police temporarily are not available, guards must be provided by the capturing unit until alternate arrangements can be made.

2-24. Medical Service to the Support Command

a. The division support command is a major subordinate element of the division. The support command is organized to provide combat service support to the division (FM 54-2).

b. Both unit and division level medical service for headquarters, support command, and subordinate units are furnished by the division medical battalion on an area basis. Subordinate units operating in the division rear are supported by the headquarters and support company; units operating in brigade areas are supported by the nearest medical company.

CHAPTER 3

MEDICAL SERVICE IN SEPARATE BRIGADES AND THE ARMORED CAVALRY REGIMENT

3-1. General

The number and type of forces provided commanders within a theater are dependent on the mission assigned and the nature of the operation. These forces may be assigned, attached, or placed in support of the command. In addition to divisions, separate brigades and armored cavalry regiments are allocated and assigned to larger forces as determined by theater commanders.

a. Separate Brigades. Separate brigades may be assigned to the field army. Brigades may be used as a rear area security force, as part of the field army reserve, or to augment the combat power of a corps. The brigade, with its attached battalions, may be assigned a rear area or flank security mission, employed as a corps reserve, or assigned or attached to a division. Combat battalions may be attached or detached for specific missions as required.

b. Armored Cavalry Regiment. An armored cavalry regiment is normally assigned to the field army and a regiment is attached to each corps. The regiment assigned to field army is normally employed as a rear area security force or as a part of field army reserve. The regiment attached to the corps normally performs reconnaissance, surveillance, and security missions over large areas. It may also engage in offensive, defensive, or retrograde operations in an economy of force role. Normally it operates under corps control but may be attached, all or in part, to a division.

3-2. Medical Service in the Separate Brigade

a. General.

(1) Medical service in the separate brigades includes both unit and division level medical service (fig. 3-1). A surgeon is included in the brigade staff. The surgeon has direct access to the commander and advises

on medical aspects of the operations and on the health of the command. In general, the surgeon has the same duties, functions, and responsibilities as discussed in paragraph 2-3. While the surgeon has no command responsibilities, he provides staff supervision of all the brigade medical services.

(2) In separate infantry, armored, and infantry (mechanized) brigades, the staff surgeon is assisted by a preventive medicine officer whose functions are as described in paragraph 2-3. In the separate light infantry and separate airborne brigades, the staff surgeon, in addition to his other duties, performs the functions of a preventive medicine officer.

b. Unit Level Medical Service.

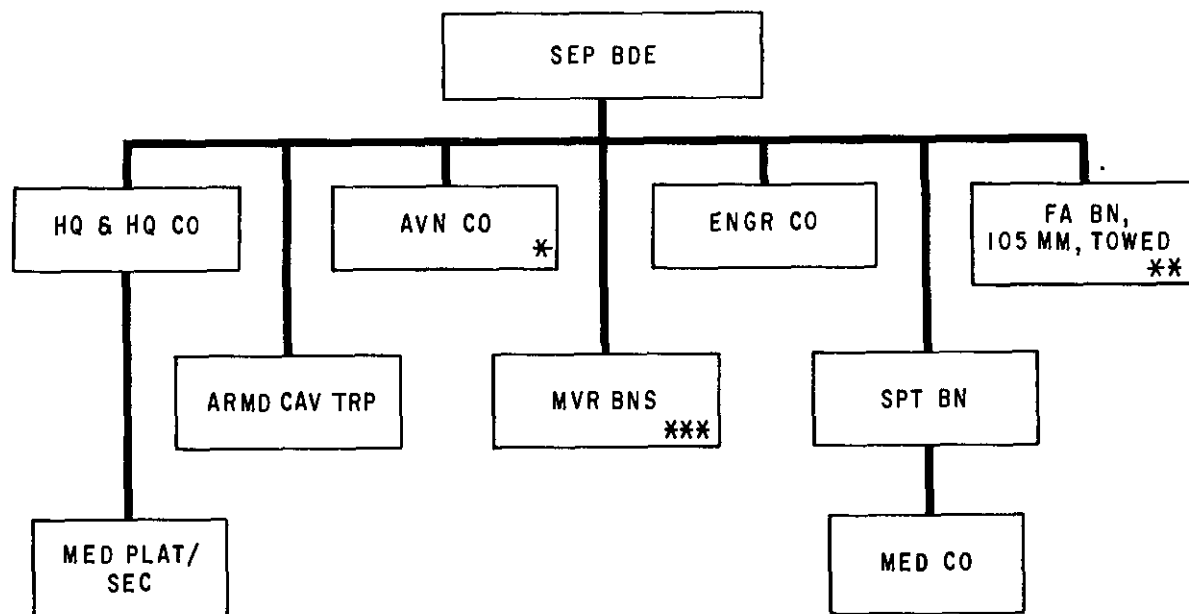
(1) The medical platoon or section of the brigade headquarters and headquarters company provides unit level medical service to the headquarters and headquarters company and to all company-size units of the brigade. The medical platoon or section may be functionally organized into a headquarters element, an aid station element, and an aid-evacuation element. Aid men are attached to the supported companies or troop, as required.

(2) Unit level medical service for the field artillery battalions and attached combat battalions is provided by organic medical platoons or sections and is identical to the service previously described in this manual.

c. Division Level Medical Service.

(1) Division level medical service for a separate infantry, armored, and infantry (mechanized) brigade is provided by a medical company, separate, TOE 8-147.

(a) Mission. The mission of the medical company, separate, is to provide division level medical service within a separate brigade or armored cavalry regiment, and unit level

**LEGEND:**

- * IN SEPARATE INFANTRY BRIGADE ONLY
- ** 155 MM SELF-PROPELLED IN SEPARATE ARMORED AND SEPARATE MECHANIZED BRIGADE
- *** NUMBER AND TYPE BATTALIONS MAY VARY

Figure 3-1. Separate brigade (infantry, armored, infantry (mechanized), light infantry, airborne).

medical service as required on an area basis to units operating in the separate brigade or regimental area.

(b) *Capabilities.* The capabilities of the medical company, separate, are described in paragraph 2-18f, except as indicated below.

1. Receive, sort, and temporarily provide medical and surgical treatment for 120 patients. Under extreme conditions, the company can provide emergency treatment for a total of 180 patients for a limited period.

2. Provide medical supply and perform organizational maintenance on medical equipment for units assigned or attached to the brigade.

3. Support two to five maneuver battalions.

(c) *Organization.* The basic organization is the same as the medical companies found in divisions (para 2-18e and f). Minor differences exist because of increased medical and surgical capability and the performance of medical equipment maintenance.

(d) *Employment.*

1. The medical company is organic to a support battalion.

2. The medical company supports the brigade from brigade trains area/bases of operation and is identical to the support provided division brigades.

3. Evacuation of the patients from the brigade clearing station is performed by the field army medical service.

(2) Division level medical service for the separate airborne brigade is provided by the Medical Company, Separate Airborne Brigade, TOE 8-167.

(a) *Mission and capabilities.* The mission and capabilities of the medical company, separate airborne brigade, are as described in (1) above, except that the medical company, separate airborne brigade, can provide treatment for 80 patients. Under extreme conditions, the company can provide emergency treatment for a total of 120 patients for a limited period.

(b) *Organization.* The organization and functions are similar to those of the medical company, infantry, infantry (mechanized), and armored divisions. Major differences include fewer personnel; addition of an X-ray capability and enlisted technicians; addition of a nurse anesthetist; and a reduction of frontline ambulances.

(c) *Employment.* The medical company supports airborne operations as described in paragraph 4-28.

(3) Division level medical service for the separate light infantry brigade is provided by the Medical Company, Separate Light Infantry Brigade, TOE 8-197.

(a) *Mission, capabilities, and organization.* The mission, capabilities, and organization of the medical company, separate, light infantry brigade, are essentially as described for the medical company, separate, airborne brigade.

(b) *Employment.*

1. The medical company, separate, light infantry brigade, is organic to a support battalion.

2. Employment is as described in (1)(d) above.

3-3. Medical Service in the Armored Cavalry Regiment

a. *General.*

(1) Medical service in the armored cavalry regiment includes only unit level medical service. Division level medical service is provided by a supporting or attached medical company.

(2) A regimental surgeon is included on the special staff of the regimental commander. The surgeon has direct access to the commander and advises on medical aspects of operation and on the health of the command. In general, the regimental surgeon has the same duties, functions, and responsibilities as the division surgeon, paragraph 2-3a, and the brigade surgeon, paragraph 2-3c. While the surgeon has no command responsibilities, he has staff supervision of the regimental medical services (fig. 3-2).

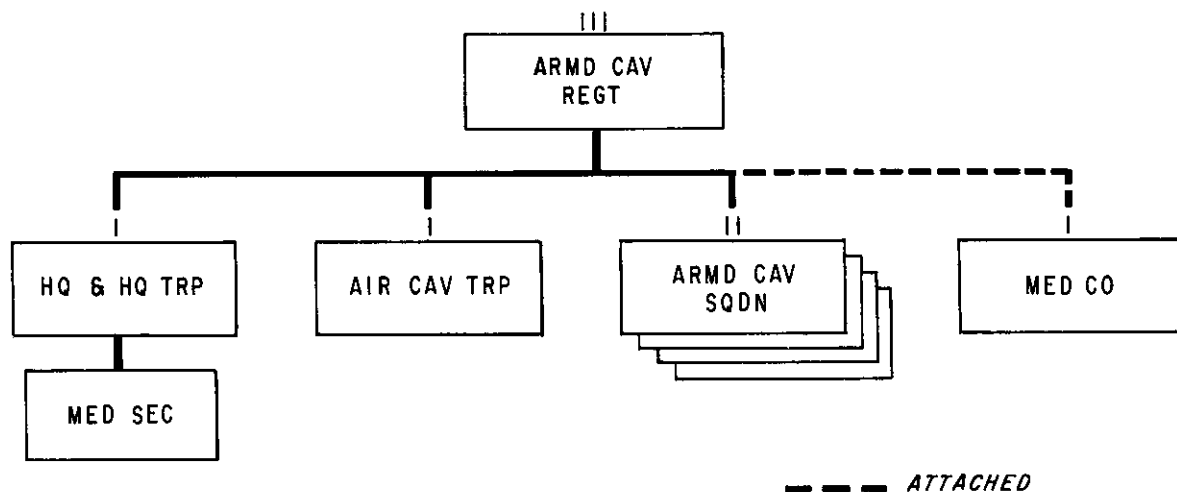


Figure 3-2. Armored cavalry regiment.

b. *Unit Level Medical Service.*

(1) Unit level medical service is provided by a regimental medical section of the headquarters and headquarters troop, armored cavalry regiment. The regimental surgeon, in addition to his other duties, assumes (with the concurrence of the commander) operational control of the medical section and is

the treatment officer of the section. The section may be functionally organized into section headquarters, aid station element, and aid-evacuation element.

(2) The aid station element establishes the aid station and provides medical treatment for patients. Aid-evacuation teams provide evacuation for the aviation company and

FM 8-15

other units that may be attached. Unit level medical service for the assigned armored cavalry squadrons is provided by organic medical sections or platoons and is identical to the service described in paragraph 2-10, armored

cavalry squadron.

c. Division Level Medical Service. Division level medical service is provided by a medical company, separate, TOE 8-147, as described in paragraph 3-2c.

CHAPTER 4

MEDICAL SUPPORT IN VARIOUS TACTICAL ENVIRONMENTS

Section I. GENERAL

4-1. Basic Considerations

a. Basic considerations which influence the use of medical units in military operations are—

- (1) Commander's plan for employment of combat forces.
- (2) Anticipated patient load.
- (3) Expected areas of casualty density.
- (4) Medical treatment and evacuation resources.
- (5) Terrain and road network.
- (6) Weather conditions.

b. The following discussion of medical support is organized by type combat maneuver. Although wide variations or modifications may be necessary, the general principles of medical service apply.

4-2. Medical Support in Offensive Operations

a. The essential characteristics of medical support in offensive operations are—

(1) Areas of casualty density which move forward, lengthen the routes of evacuation, and thus require forward displacement of supporting medical treatment stations.

(2) Heaviest patient loads occur during disruption of enemy main defenses, at terrain or tactical barriers, and during the assault of final objectives.

b. Generally, in offensive operations, division medical treatment stations are initially located as far forward as combat operations permit.

c. Medical treatment elements at all levels insure complete prescribed loads of medical materiel on hand prior to an attack.

d. Division medical elements may be required to furnish temporary emergency medical support to indigenous, displaced persons, or refugees, as a humanitarian act and also to

prevent their interference with combat operations. The extent of this support is decided by the division commander, but support is normally confined to emergency treatment.

4-3. Medical Service in Movement to Contact

a. March medical service is used primarily to support movement to contact. Medical units or elements are deployed in accordance with the overall medical plan for support of the attack before beginning movement. Prior deployment permits uninterrupted medical support of forces moving to contact and allows for a smooth transition to support the initial phase of the offensive maneuver.

(1) When the covering force is battalion size or larger, medical resources are normally reinforced by the division medical battalion. Attachment of a division clearing element is seldom required. Ambulances may evacuate patients of the covering force directly to the division clearing station. Supporting air ambulances are used wherever feasible.

(2) Advance, flank, and rear guards normally receive medical support through the attachment of aid-evacuation teams using frontline ambulances or armored personnel carriers. Patients are evacuated to predesignated patient collecting points or to the nearest treatment station.

(3) A movement to contact should be supported by partially established medical treatment facilities. Battalion aid stations may operate from vehicles whenever possible. If the terrain permits, only one division clearing station may be necessary.

b. When the attack is preceded by a relief in place or passage of lines, extensive liaison with medical elements of the unit to be relieved or passed through is required to insure

medical support. In a passage of lines, the participating division surgeons arrange for the units in place to accept the initial casualties of the attacking unit to allow for the treatment element of the latter to maintain mobility and begin their service farther forward. The ensuing combat mission of the passed unit dictates the extent to which this cross-support can be provided. Medical elements of a unit relieved in place provide the relieving division information concerning potential or established patient evacuation routes and sites for treatment stations.

4-4. Medical Service in Penetrations

Of all the offensive operations, the penetration may produce the heaviest medical workload. Heavy fire from the enemy can modify the basic requirement of placing medical treatment stations and ambulances as far forward as possible. Patient collection is slow initially, but will become more rapid as the attack progresses. Ambulance evacuation may be slow and difficult because of damage to roads. The use of available Army aircraft will expedite patient evacuation. Treatment facilities established to support the penetration must be large enough to handle anticipated heavy patient loads and at the same time be prepared for rapid transition to exploitation and pursuit. Medical means in an exploitation must remain as close to the supported forces as combat operations permit. Battalion surgeons may establish company aid posts in addition to patient collecting points to support operations requiring a wide dispersion of combat elements. Company aid men must continue to provide emergency treatment of patients awaiting evacuation when companies are temporarily isolated from their medical support. Medical support elements must be located on each flank of the penetration since evacuation cannot take place across an avenue of heavy combat traffic. In addition, the avenue may be a likely target for enemy attack.

4-5. Medical Service in the Envelopment

a. Since the envelopment does not involve direct breach of the enemy's principal defensive positions, the medical workload may not be great. Rapid movement and light combat are anticipated; thus, medical support is es-

entially the same as in the movement to contact. Ambulances, however, are echeloned forward in both levels of medical support for rapid evacuation of patients. Aid station sections and clearing platoons overtake patients during evacuation and reduce this treatment delay factor. Commanders of treatment elements maintain contact with the combat situation through command communication channels. Commanders determine the appropriate size and time to establish aid stations based on the tactical situation. Division level medical units may be attached to the brigade for the duration of the operation.

b. The mobility of medical units supporting an envelopment should not be jeopardized by prisoner-of-war or nonmilitary patient workload. If such workload is anticipated, reinforcement of division medical resources must be provided and indigenous military and civilian medical facilities used whenever possible.

c. When the maneuver includes vertical envelopment, division medical elements, which are transportable by light or medium helicopters, accompany the airmobile force. Anticipated delay in linkup may require commitment of additional treatment and holding facilities to the airmobile force relying mainly on air ambulances for evacuation of patients. Airmobile operations in an isolated airhead may require complete reliance on Army aeromedical evacuation or patient movement by other Army aircraft returning from the airhead.

4-6. Medical Service in Exploitation and Pursuit

Combat units involved in exploitation and pursuit employ virtually the same tactics as in the envelopment; therefore, medical support operations are similar to those previously discussed. Control of required division level medical support is frequently decentralized to combat brigade level. Insecure ground routes may force reliance on evacuation by intermittent ground ambulance convoy or air ambulance. As exploitation and pursuit seldom can be planned in detail, medical operations adhere to standing operating procedures and continuing adjustments by battalion and brigade surgeons. Successful improvisation of medical support to assist rapid movements re-

quires exceptionally good communications and uninterrupted contact with the supporting medical unit.

4-7. Medical Service in Infiltration

a. Infiltration is a technique of movement used in conjunction with offensive operations. The division normally employs infiltration techniques with a portion of the division in conjunction with offensive maneuver by the remainder of the division.

b. Infiltrating elements pass through, over, or around the enemy's forward defensive positions, avoiding detection where possible and, if detected, avoiding decisive engagement.

c. Medical support of infiltration is restricted by the amount of medical equipment, supplies, and transportation which can be introduced into the attack area. For example, a maneuver battalion can man-carry enough aid station equipment into the attack area to provide basic support. Patients must be evacuated to the aid station by litterbearer teams composed of aid-evacuation team members of the combat battalion medical platoon. The battalion medical platoons may require reinforcement by the division medical battalion; field army level medical personnel; or by improvisation of litter teams using combat troops if so directed or approved by the tactical commander. Evacuation from battalion aid stations may also be by litterbearers, depending on distances and the degree of secrecy involved.

d. When airmobile forces are used, infiltrating groups may land at various points in the enemy's rear and proceed on foot to designated attack positions. As in a surface movement, the amount of medical equipment taken may be limited. The evacuation of patients will be by litterbearer to collection points or to the battalion aid station and then by air ambulance to a division clearing station or hospital. Once the maneuver element begins the assault on its objective, secrecy is no longer paramount, and its isolated location requires medical support as in airmobile operations until ground linkup.

4-8. Medical Service of the Reconnaissance in Force

a. The reconnaissance in force is an attack to discover and test enemy positions and strengths, or to develop other combat intelligence. The division may probe with multiple combat units of limited size, retaining sufficient reserves to exploit enemy weaknesses.

b. Medical support of the reconnaissance in force closely follow those discussed for the movement to contact in paragraph 4-3. Ambulances are echeloned forward, both at unit and division levels, to insure prompt acquisition and evacuation of patients. Treatment stations are not established until a significant patient workload develops. Patients received at aid stations of reconnoitering units are evacuated to division clearing stations as early as practicable or retained with the force until there is suitable opportunity for evacuation.

Section II. MEDICAL SERVICE OF DEFENSIVE OPERATIONS

4-9. General

a. Defensive operations are actions to prevent, resist, repulse, or destroy enemy attack. The defense is undertaken to develop more favorable conditions for subsequent offensive operations; economize forces in one area in order to apply decisive force in another; destroy or trap a hostile force; deny an enemy entrance to an area; or reduce enemy capability with the least possible losses to friendly forces.

b. The fundamental forms of defense are mobile and area defense. Most defensive postures for a given situation will be some vari-

ation of either the mobile or area defense and will incorporate characteristics of each.

4-10. Medical Doctrine in Defense

a. Medical support in the defense is more difficult than in the offensive. Patient loads reflect a lower casualty rate, but forward area acquisition of patients is more complicated by the initial direction of maneuver to the rear. Medical personnel who are more directly exposed to enemy attack than in the offense, are permitted less time to reach the casualty, provide vital emergency medical treatment, and remove him from the battle site. Increased casualties among exposed medical personnel

will further reduce the medical treatment and evacuation capability.

b. Heaviest patient workloads, including those produced by enemy artillery and chemical and nuclear weapons, may be expected during the initial phase of enemy attack and during the counterattack. The enemy attack may disrupt ground communication routes and delay evacuation of patients to and from aid stations.

c. Reserve combat forces play a decisive role in the defense and the location of medical treatment stations must not restrict their maneuver. Division level medical units, commensurate with the size and composition of the reserve, are initially withheld from operations for immediate commitment in support of the reserve.

d. The depths and dispersion of mobile defense create significant time and distance problems in patient evacuation support to security and fixing forces. Security forces may be forced to withdraw and simultaneously transport remaining patients to the rear.

e. The enemy's initiative early in the operation may prevent accurate prediction of initial areas of casualty density.

f. Division clearing stations are established and kept as mobile as possible by frequent evacuation of patients.

g. The disposition of medical service units and facilities in defense is based on the division commander's overall defensive plan. In mobile defense, such disposition must anticipate the withdrawal of certain forward units. In the area defense, however, such withdrawal will not be contemplated. The dispositions to be made in case of unsuccessful defense and consequent withdrawal are discussed in paragraph 4-17.

h. Medical facilities will be located farther to the rear in the defense than in the offense.

4-11. Medical Service in Mobile Defense

a. Mobile defense is that form of defense in which minimum forces are deployed forward and priority given to the use of mobile combat elements and fires concentrated in the reserve. Primary reliance is placed upon the use of offensive action by the reserve to destroy enemy forces.

b. Defensive areas include the security area, the forward defense area, and the reserve area. Medical service for each of these areas is described in paragraphs 4-12 through 4-14.

c. In mobile defense, distances between defensive units are greater. Normal medical support is provided, but increased use of collecting points may be necessary. Aid-evacuation teams may be attached to rifle companies.

d. The nature of the fixing force's mission and employment requires modification of normal division medical support. The threat of enemy penetration and need for countering maneuver may prohibit the establishment of a clearing station forward of the reserve force. Long, insecure ground routes may permit patient evacuation at periodic intervals only.

(1) Most of the division's strength is deployed to the rear of the forward defense area. The forward elements do not normally expel the enemy by attack. At the appropriate time, the division reserve counterattacks to destroy or expel the enemy.

(2) Clearing elements must remain as free as possible of any heavy patient accumulation to avoid the immobilization of these elements. Thus, the field army medical service must provide close and continuous patient evacuation support to the division.

4-12. Medical Service of Outposts and Covering Forces

An outpost is a security force posted at some distance from the main body of troops for protection from hostile ground observation and surprise attack. The medical service of an outpost will depend upon the organization, size, mission, and characteristics of the outpost.

a. Unit Medical Service. The general procedures of medical service in retrograde movements apply in the withdrawal of outposts. The wide dispersion of units and the rapidity with which they withdraw make collection of patients difficult. If withdrawal is slow and interrupted by vigorous enemy resistance, aid stations may be partly established and medical service is comparable to that of defense. When the withdrawal is rapid, however, time may not permit the full establishment of medical facilities. Ambulances move along convenient

routes and litterbearers carry patients to the ambulances. The withdrawing combat troops should assist in the transfer of patients to ambulances when possible or carry their own patients if necessary. Helicopters may be used to evacuate patients, particularly in rapidly moving situations.

b. Division Level Medical Service. If a medical company is attached to the security force, it operates under the control of the security force surgeon. Clearing stations are established to the rear of the main defense force and result in long evacuation routes. The size of the security forces and the low casualty rate expected require only a minimum commitment of division ambulances. The responsiveness of the division ambulances committed to this mission may be improved by—

- (1) Use of supporting air ambulances.
- (2) Shuttling of patients to the nearest aid station behind the line of contact to reduce ground ambulance turnaround time.

4-13. Medical Service of the Reserve (Mobile Defense)

a. Generally, the medical support discussed in paragraph 4-5 applies to medical service of the reserve. Organic and direct medical support elements must maintain full mobility prior to contact with the enemy. Battalion aid stations provide "tailgate treatment support" and clearing platoons do not usually establish complete stations. Tailgate treatment support is a treatment technique used while supporting a fast-moving maneuver in which patients may be treated in ambulances, in civilian shelters, or on the ground along the route of movement. The probability that initial contact with the enemy will produce the decisive engagement decreases the possibility of having to move patients forward. Therefore, both the aid and clearing stations normally establish complete stations at initial locations.

b. When the reserve attacks major enemy penetrations in the division zone, an abnormally large load of prisoner-of-war patients may result. The division medical plan should include prearranged, oncall reinforcement by

field army medical evacuation and treatment units. This reinforcement supports the prisoner-patient workload, permits division medical units to continue support of combat operations, and prevents interference with tactical operations.

4-14. Medical Service in Area Defense

a. The area defense is that form of defense which emphasizes retention of, or control over, specific terrain. Defensive areas include the security area, the forward defense area, and the reserve area. Except in the counterattack, combat units in area defense remain fixed. Local and general reserves may move from time to time, but units occupying defensive positions remain stationary.

b. In a division operation, the forward defense area forces normally consist of two brigades. Each brigade is supported by a medical company of the division medical battalion. The maneuver battalions of the brigades are provided unit level medical service by organic medical platoons.

c. The aid station should be located centrally for protection and to shorten evacuation routes. Complete stations may be established when a significant patient load is expected. Medical aid-evacuation teams should not be deployed prematurely and should be allocated only when the direction of the enemy attack becomes apparent. The probable areas of casualty density, the characteristics of the terrain, the organization of the defensive area, and the distances to the collecting points or company aid posts must all be considered in allocating medical aid-evacuation teams. Collecting points or company aid posts should be established near each rifle company command post as control and transfer points for litter and frontline ambulances.

d. Division clearing stations are established well to the rear in order to provide protection from enemy action and to avoid interference with the reserve force. Division ambulances are used as required. A large reserve of ambulances should be retained until the direction and scale of the enemy attack is established.

Section III. MEDICAL SERVICE IN RETROGRADE OPERATIONS

4-15. General

A retrograde operation is a movement to the rear or away from the enemy. Such an operation may be forced by enemy action or may be made voluntarily. These movements are classified as a withdrawal from action, a retirement, or a delaying action.

4-16. Medical Service in Retrograde Operations

The medical problems involved in retrograde movements may vary widely depending upon the operation, the enemy reaction, and the situation. Firm rules that apply equally to all types of retrograde operations are impossible to establish, but certain factors must be considered in medical planning in all retrograde operations.

a. Time Factor. The number of patients removed from any battlefield is dependent upon the time and means available. In stabilized situations and in the advance, time is important only as it affects the physical well-being of the injured. In retrograde operations, time is more important. As available time decreases, the surgeon must evaluate the capacity to collect, treat, and evacuate all patients.

b. Evacuation.

(1) Routes of evacuation will be required for the movement of troops and materiel, causing patient evacuation in retrograde movements to be more difficult than in any other type of operation. Communication and control may be disrupted by the enemy. The measures taken to withstand factors impeding evacuation during retrograde movements are beyond the scope of medical authority. If evacuation is to be successful, the appropriate commander must take positive action. Successful evacuation requires—the inclusion of ambulances on the list of priorities for movement; provision for the transportation of slightly wounded in cargo vehicles; and directives to subordinate commanders defining responsibilities in the collection and evacuation of patients.

(2) Mobility of division clearing stations will be enhanced by evacuating patients directly from battalion aid stations to hospitals.

(3) Special emphasis must be placed on

the sorting of patients, and consideration must be given to the type of transportation available for evacuation. Seriously wounded patients should be evacuated by the fastest and most comfortable means. Proper sorting and rapid evacuation of patients will assist evacuation and lessen the need for establishing complete medical treatment stations.

(4) Patients who cannot be evacuated must be left behind. There is no middle course. The medical service is not alone in the responsibility of preventing the capture of patients, but shares this responsibility with the commander. *The tactical commander must make this decision*, and the surgeon must insure that timely notice of the need to reach a decision is given to the commander. Medical personnel and supplies must be left with patients who cannot be evacuated.

c. Location of Medical Facilities. During a retrograde movement, medical facilities usually displace by echelon and hold patients for a short period of time. Locations for successive positions from forward to rear areas for every medical facility involved must be planned in advance. Since the general direction of movement is toward medical facilities, initial locations must be placed farther to the rear than in other types of operations. The next rearward location always must be occupied by a medical unit prepared to function before the forward location is closed.

d. Displacement. Frequency of displacement will be determined by the rate of movement, the terrain, and security. Medical facilities must be displaced before there is danger of involvement in the actions of forces conducting a retrograde movement. Displacements can be made either by echelons within the units, or by echeloning complete units.

e. Future Operations. Operations to be undertaken at the conclusion of the retrograde movement must be considered when planning the medical service for such movement. This consideration is most important in preparing for the later phases of movement.

f. Coordination. When the retrograde operation involves a rearward passage of lines, ad-

vanced planning between surgeons of passing and passed divisions is required. The surgeon of the divisions being passed provides information concerning the location of his division forces and the evacuation routes. Both surgeons develop a coordinated plan for joint support of an abnormal patient workload which may develop in either division during the passage of lines. Overconcentration of forces, which presents a lucrative target to the enemy, is a primary hazard in the passage of lines. The division establishes only as many medical treatment stations as necessary to accommodate the expected patient workloads. In planning the location of treatment stations, detailed attention is given to selecting sites which offer the enemy no indication of the location of major elements in either division. The medical plan for support of both divisions usually specifies that the passing division transports its own patients to the rear. Critically ill or injured patients, however, may be passed to the division in place.

4-17. Medical Service in the Withdrawal

A withdrawal is an operation in which a deployed force disengages from the enemy.

a. In a voluntary withdrawal, medical service is modified by the rearward movement of troops. The usual allocation of aid men and aid-evacuation teams is made and small treatment and ambulance elements march at the rear of the main body. This element collects patients at collecting points predesignated by the division medical plan. Except in emergency evacuation, elements of the security force may be required to transport patients to the next designated battalion assembly area when patients cannot be shuttled to the medical treatment element. Patients are transported with the rear element to the new aid station. Temporary halts at battalion assembly points permit the rear element to evacuate patients according to the division medical plan.

b. A voluntary withdrawal usually requires movement of combat columns through a division covering force. Unit medical service of the covering force is discussed in paragraph 4-12. Division SOP prescribe priorities for use of general purpose transportation in patient

movement. When the force must displace rearward without sufficient ambulances, standing operating procedures provide the covering force commander with basic guidance of alternate evacuation plans.

c. Supporting medical companies establish clearing stations as far to the rear of the first line of alternate positions as possible. If combat and environmental conditions indicate a light patient load and the road net permits rapid ambulance movement, laterally and along the axis of withdrawal, one or two clearing stations may be used to provide general support to all withdrawing brigades. Clearing station activity consists mainly of sorting of patients to determine evacuation priorities, and need for prompt, emergency, and resuscitative treatment for early evacuation. Definitive treatment is provided only to those patients who are reasonably self-sufficient and who can travel with little jeopardy. Clearing stations echelon rearward by positions and occupy successive positions along the withdrawal route. This rearward movement—reduces the requirement for multiple displacements by any one platoon; avoids unnecessary interference with combat operations; and allows for continuous medical support. Division ambulances are employed as required. In a voluntary withdrawal, an ambulance element may be required to support the covering force. When withdrawal is rapid, ambulance elements may leapfrog rearward. These elements preposition vehicles to support each succeeding aid station location instead of shuttling ambulances between aid and clearing stations. Preparation for the withdrawal includes distribution of extra consumable medical supplies and nonexpendable exchange items to each medical unit or element. The special allotment is required to overcome results of abnormal isolation of treatment elements and the intermittent operation of the patient evacuation system.

4-18. Medical Service in Retirement

a. Retirement is an operation in which a force moves away from the enemy to avoid combat under existing conditions. A withdrawal may precede a retirement.

b. Medical support in a retirement is similar to that provided in march medical service. Patient workloads are usually light; however, reinforcement of ambulances for support of the rear guard may be required. Treatment and evacuation support marching at the rear of the main body is as discussed in paragraph 4-3. Division clearing stations are located well to the rear.

4-19. Medical Service in Delaying Action

A delaying action is an operation in which a

force under enemy pressure trades space for time while inflicting maximum punishment on the enemy without becoming decisively engaged. The division may conduct a delaying mission by—delaying on successive positions; delaying on alternate positions; or a combination of both (FM 61-100). Medical service similar to that described in paragraph 4-17 is provided for the force.

Section IV. MEDICAL SERVICE IN SPECIAL OPERATIONS

4-20. General

a. The effectiveness of medical support is limited to the same degree as combat effectiveness when operating in areas characterized by extreme weather and terrain conditions. Division medical units are medically equipped to perform in any environment. These units, however, require special purpose equipment (primarily shelter and transportation) in type and quantity commensurate with their support mission. During movement and at operating sites where extremely hot or cold temperatures exist, continuous protection is necessary for medical items and supplies that deteriorate rapidly. Unusual types and larger numbers of patients often result from prolonged exposure to extreme environmental conditions. Division medical units have the capability to treat unusual disease or injury within the limits of their mission. Abnormally large numbers of patients require augmentation of division treatment and evacuation resources.

b. In general, the principles of medical service as previously discussed are applicable under extreme weather and terrain conditions. Variation of these principles may be expected. Whenever medical planning is concerned with operations of this type, special consideration must be given to these abnormalities and the effect upon prompt medical treatment, evacuation, and hospitalization.

4-21. Medical Service in Desert Operations

a. The large area over which a battle is fought presents special problems in the evacuation and treatment of patients. A large number of patients in a highly mobile unit restricts action and may endanger that unit.

Medical units may be reinforced with a larger number of ambulances in desert operations than in other terrain. These units also may be given direct support by an air ambulance detachment or platoon. Aeromedical evacuation is of great value because of greater speed and the reduction on the ground vehicle load (FM 31-25).

b. The comparatively long distance between units may limit the availability of medical aid men to adequately support combat troops. Reinforcement may be required from the division medical battalion or from supporting field army medical units.

c. In order to treat patients properly, all medical treatment facilities should be provided additional supplies of water. Heat cramps, heat exhaustion, and heatstroke are prevalent in a desert environment. Medical personnel at all levels must assist commanders in preventing or reducing unnecessary heat casualties.

d. Medical facilities at all echelons are located farther to the rear than normal.

4-22. Medical Service in Mountain Operations

Mountain warfare is characterized primarily by the difficulties encountered in movement. The inaccessibility of certain regions restricts areas where troops can operate, and limits the strength of forces which can be maintained and moved therein (FM 31-72).

a. The proportion of litter cases to ambulatory cases is increased in mountainous terrain, for even a slightly wounded individual may find it difficult to negotiate the terrain. In

addition, improvised means such as travois or tramway may have to be used.

b. Aeromedical evacuation of patients should be used whenever possible. The reduction of time between injury and treatment is a determining factor in the success of medical treatment and the time required for a patient's recovery. Therefore, the safest, most rapid, and most comfortable means of evacuation is desirable and often mandatory. Prior planning should include consideration of aircraft limitations and suitable methods of evacuation.

4-23. Medical Service in Jungle Operations

The general principles of medical service apply in jungle operations; however, wide variations may be expected. The manner in which medical units support tactical organizations depends on the employment of the supported unit (FM 31-30).

a. The greatest problems in providing adequate medical service in jungle operations are the widely dispersed troop units, lack of adequate roads, and insecure lines of communications. In addition, a larger number of litter patients can be expected, since even slightly wounded individuals may find it impossible to struggle through dense undergrowth. As a result, the patient ordinarily classified as "walking wounded" may become a litter case.

b. Aeromedical evacuation is often the only means of evacuating patients. Air ambulances have a hoist capability for lifting patients through a canopy of dense jungle foliage. Frequently, patients will be evacuated from forward positions. In many cases, evacuation begins near the site of injury. Battalion aid stations may be bypassed by air ambulances, and patients taken to division clearing stations located in the brigade area.

c. Air ambulances, if not organic, may be placed in direct support of divisions or brigades and normally will operate from forward brigade areas. Additional information on aeromedical evacuation will be found in chapter 6.

d. Total reliance on air ambulances is inadvisable. All available means of collection and evacuation must be used.

4-24. Medical Service in Snow and Extreme Cold

Military operations conducted under conditions of snow and extreme cold follow the same basic principles previously described. They differ primarily in the tactical and logistical limitations imposed by adverse climatic conditions and in special types of equipment, training, and procedures necessary to overcome these limitations (FM 31-70 and FM 31-71).

a. Cold accelerates shock and reduces recovery possibilities of exposed patients. Evacuation by litter is extremely difficult under conditions of cold and deep snow, and litter-bearers are subject to excessive fatigue. Arctic conditions make surface evacuation of patients difficult in winter and virtually impossible in summer.

b. The most practical means of patient evacuation is by helicopter. Air ambulances may be attached to divisions during northern operations and will perform the majority of division evacuation. Total reliance on air ambulances must be avoided, for helicopter operations will be restricted by adverse weather conditions.

c. Medical technicians should have training, experience, and self confidence to manage patients awaiting evacuation. Technicians should be able to treat wounds or injuries when a medical officer is not immediately available. During severe weather or intensive enemy action, aid men may be required to tend the seriously wounded for several days.

d. To reduce deaths among patients in extremely cold weather, the following apply:

- (1) Prompt acquisition and evacuation of patients to heated treatment stations.
- (2) Augmentation of collecting elements of both unit and division medical service.
- (3) Use of inclosed and adequately heated transportation for medical evacuation.
- (4) Provision of heated shelters at frequent intervals along the route of evacuation.
- (5) Readily available air transportation for evacuation.
- (6) Special snow-traversing-type vehicles for medical surface evacuation.
- (7) Heated storage for medical supplies.

4-25. Medical Support of Airmobile Operations

a. All divisions may participate in airmobile operations by augmentation of aircraft. Army Medical Service air ambulances ordinarily will be in direct support (FM 57-35).

b. Medical service for airmobile operations is essentially the same as that for all other operations. At the unit level, company aid men are deployed with the infantry companies. Elements of the battalion aid and evacuation sections may be airlifted to the battalion base and elements of a supporting medical company may be moved to a brigade base. Company aid men duties are as described in paragraph 2-8c. In some cases, the battalion aid station will not be located in the battalion base, but may be established in the brigade base where the battalion aid station personnel work in conjunction with the clearing station. Unit level medical service is similar to that previously described for the airmobile division.

c. Division level medical support for airmobile operations is essentially as described for the airmobile division. Air ambulance detachments or elements of an air ambulance company provide support to a division or brigades of a division. Air ambulances will evacuate patients from forward positions (e.g., isolated positions, aid posts) to either battalion aid stations, division clearing stations, or supporting hospitals. The use of organic ground ambulances at all levels may be restricted to use within secure bases; therefore, evacuation may be entirely by air for both lightly and severely wounded patients. The requesting of air ambulances should be made only when the landing zone is secure and after the immediate battle situation has been settled.

d. Air ambulances normally will be based in the brigade base of the supported brigade and will accompany flights into a landing zone. Requests for air ambulances will be as described in paragraph 6-5.

4-26. Medical Service in Amphibious Operations

a. In an amphibious operation, the U.S. Army battalion landing team (BLT) is the basic subordinate task organization of the assault echelon of the landing force. It consists

of a combat battalion reinforced with necessary combat support and combat service support elements from division or a higher echelon.

b. During the assault phase, patients are collected and treated by organic medical personnel, and evacuated to the shore party medical evacuation station. At this station, patients are classified and evacuated to casualty control evacuation ships. At the control ship, patients are treated, further sorted, and evacuated to the casualty-carrying ship.

c. Control of division level medical operations is initially decentralized to supported brigades, but reverts to the medical battalion as soon as communications and rear area security permit.

d. Aeromedical evacuation is an important part of the evacuation system and must be integrated in the early planning phases. Aeromedical evacuation is initially reserved for patients requiring emergency surgery. Later, all patients may be evacuated directly to pre-designated ships. In operations of this type, air ambulances will be attached to divisions.

e. Details of the phased buildup of division medical support ashore, and coordination with the supporting medical organization afloat which includes the connecting beach evacuation function are provided in FM 31-12 and FM 31-13.

4-27. Medical Service in Independent and Semi-Independent Operations

a. United States Forces assigned to an area of operations may range from relatively small task forces to a full array of large land, sea, and air forces. The U.S. Army element in the force may vary from a division or less to one or more Army groups with the necessary combat and combat service support. The organizational structure will change in complexity with the size of the forces committed.

b. The Army division is tailored for the environment and the performance of specific missions. Separate brigades or brigades of a division acting independently are similarly tailored and are capable of operating in all situations.

c. When operating separately, independently, or semi-independently, divisions and bri-

gades require medical support beyond that which is organic or attached from division resources. In planning medical support for these forces, the evacuation policy must be known; that is, the period a patient will be retained for treatment before being returned to duty or evacuated from the area. A theater evacuation policy is established by the Department of Defense as recommended by the Joint Chiefs of Staff. The degree and extent of medical support for such forces is dependent, in part, on the evacuation policy. FM 8-55 and FM 101-10-1 should be used as a guide in determining the types and numbers of medical units require to support a given force.

d. Ordinarily, a force surgeon who coordinates the medical service will be designated. The surgeon's duties, functions, and responsibilities are as discussed in paragraph 2-3a and *c*.

4-28. Medical Service in Airborne Operations

a. General.

(1) The airborne division is a specialized unit designed to conduct airborne assaults. Entry into combat is by airlanded or parachute means. Although organized for short-duration operations, the division is capable of sustained combat when properly augmented.

(2) The general principles that govern operations of the medical service as previously discussed also apply to forces engaged in airborne operations. After linkup occurs between the elements of the airborne division and the troops making the main ground effort or the establishment of air evacuation from the airhead, the medical service of the airborne division does not differ materially from that of a division in ground operations. Only those aspects which are different will be discussed herein.

b. Basic Considerations.

(1) Basic considerations which influence the use of division medical resources, other than those previously discussed are—

(a) Heavy casualties may develop during assault drops. Initially, division medical treatment stations may experience an overload of patients because of delay in evacuation out of the airhead.

(b) Simultaneous medical support to three brigade task forces may be required during the early phases of the assault.

(c) Aircraft space limitations and drop losses reduce ambulance availability in the airhead.

(d) The division surgeon must rely on division nonmedical aircraft for evacuation of patients selected for air movement. Air ambulances of the field army medical service may be flown in or airlanded with followup echelons to provide intra-airhead aeromedical evacuation in prolonged operations.

(e) The Air Force is responsible for patient evacuation from airheads. Aircraft used to airland elements of the assault echelon are the first available for patient evacuation. Prior to establishment of Air Force casualty staging facilities, division medical treatment elements hold patients at the landing zone and assist in manifesting and loading patients on Air Force aircraft for evacuation out of the airhead. In airborne assaults of smaller than division size where time, distance, and air superiority permit, Army air ambulances, operating in an Army air line of communications, may evacuate patients out of the airhead.

(f) The intra-airhead medical support area is usually circular in physical configuration with division clearing and ambulance elements centrally located to support battalion aid stations established near the airhead line. Evacuation route distances are usually shorter than in other division operations.

(2) Unit level medical service includes—

(a) *Loading of personnel.* Key medical personnel are loaded into several different assault aircraft in order that the loss of one aircraft will not paralyze the medical service of the combat battalions. Company aid men are loaded in the aircraft with the supported units. One ambulance team should be included in assault loads of each combat company.

(b) *Medical service during the initial assault phase.* During the initial phases of the attack, medical care must be provided promptly and efficiently. In addition to casualties caused by enemy fire, there may also be jump injuries or crash victims requiring treatment in the drop or landing zone.

1. Company aid men treat patients in their zone and move out with the units to which attacked. The location of the wounded must be well marked and, if possible, patients should be assembled in small groups at collecting points located near suitable airlanding fields in order to expedite subsequent evacuation.

2. Evacuation of patients from the site of injury or from collecting points to aid stations is performed by personnel of the evacuation section of the medical platoon using ambulances or nonmedical vehicles and aircraft when available.

3. The battalion aid station is located initially in the combat battalion assembly area. The aid station moves out of the assembly area with the battalion in accordance with the tactical situation.

4. During the initial assault phase, patients requiring evacuation from the airhead are assembled near the landing strips in the division or brigade area. Patients are air-lifted by assault transport aircraft from the airhead directly to medical treatment facilities in the combat or communications zone. The division surgeon coordinates this activity with the brigade surgeon; however, the brigade surgeon, without access to the division surgeon, may arrange such evacuation, if required, during early phases.

(c) *Medical service during the later phases.* With the arrival of vehicles and additional equipment by air delivery, airlanding, or ground linkup, the medical service of the combat battalion becomes similar to that in any ground operation.

c. *Division Level Medical Service of the Airborne Division.*

(1) The limited capability of the combat battalion medical platoons to treat and hold patients makes it imperative that the airborne division medical companies be delivered into the airhead as soon as possible. In special missions involving an airborne task force of one reinforced airborne brigade, attachment of division medical company elements may be necessary to reinforce the medical platoons of the airborne combat battalions.

(2) The anticipated timelag that separates the airdrop and airland phases of the assault determines the strength and nature of attachment of division level medical resources to combat battalions or brigades. The medical platoon of each airdropped combat battalion is accompanied by a liaison agent from the medical company designated to support the battalion's parent brigade. The liaison agent contacts the supporting medical company upon its arrival in the airhead, and provides the company commander with information concerning the location of the battalion aid station, the medical workload, and evacuation routes. When the plan for combat operations indicates that the medical platoon may bear total responsibility for intra-airhead medical support for a prolonged period, the platoon should be reinforced in the airdrop phase by both division ambulance and treatment resources. Ambulances are used to improve the platoon's patient acquisition capability and, early in the airlanded phase of the assault, to evacuate patients to landing zones for movement out of the airhead, in accordance with schedules established in the division administrative order. Additional treatment resources permit the aid station to accommodate the abnormal accumulation of patients prior to evacuation out of the airhead or establishment of the supporting division level clearing station.

(3) Elements of the medical battalion will be divided into several aircraft serials so that loss of one serial will not cause the loss of all key personnel and equipment. In the event the entire battalion is to be airdropped, accompanying equipment will be rigged and airdropped into the airhead.

(4) Most elements of the division medical battalion may be brought into the airhead during the airland phase of the assault. All battalion units may be parachute-delivered if necessary. One medical company normally is attached to each committed brigade to facilitate operational control by the brigade commander. To insure effective use of the limited medical resources available in the airhead, medical battalion headquarters resumes control of subordinate companies supporting the bri-

gades as early as possible. Medical companies supporting brigades are scheduled for deployment early in the airland phase to provide prompt relief for battalion aid stations. Unless the brigade mission requires offensive action over extended distances, the supporting medical company establishes a full-size clearing station near a landing zone located centrally in the brigade sector. When significant delay is anticipated between its deployment and the scheduled arrival of Air Force patient-staging elements in the airhead, the medical company may be reinforced by division or by field army medical resources to assist in holding and loading patients aircraft. Reinforcement of medical company ambulance resources is provided to insure the capability of simultaneous support to battalion aid stations and evacuation of patients from the clearing station to the landing zone embarkation point.

(5) Evacuation of division clearing stations may be by one or a combination of the following methods:

(a) Aeromedical evacuation from the airhead by the Air Force.

(b) Evacuation to airlanded field army medical units in the airhead.

(c) Evacuation through normal channels after ground linkup.

(6) Division combat operations subsequent to the assault employ the tactics discussed in preceding paragraphs of this chapter. Generally, support of subsequent operations requires no special medical tactics. If patient evacuation from the airheads has been accelerated during the assault and subsequent operations, no overwhelming load of patients remains to impede withdrawal by air.

(7) Medical elements of a division directed to link up with the airborne element should be prepared to supplement airhead medical support immediately. Medical support includes acceptance of patient overloads and elimination of surgical backlog in airhead clearing stations. Reinforcement of the linkup division's medical service may be required to perform this relief mission.

d. Medical Supply in Airborne Operations.

(1) Delivery of all supplies to the objective area is by air. Care must be taken that no

critical items of medical supply are omitted, for resupply may be delayed. Losses of supplies and equipment must be anticipated, therefore critical items must be duplicated and loaded on separate aircraft. Aircraft requirements and availability must be considered in medical supply planning for airborne operations. Phases of supply are accompanying, followup, and routine supply.

(2) Since medical support is provided initially by dispersed units supported by unreliable lines of communication, accompanying medical supplies are widely disseminated to battalion medical platoons and to elements of the division medical battalion. During the early assault period, medical resupply to individual brigades is direct from departure airfields. When the division airhead is consolidated, the division medical supply point resumes its normal functions. Division medical supply liaison personnel may remain at a departure airfield to coordinate dispatch of followup medical supply to the division airhead.

4-29. Medical Service of Combat at River Lines

a. Attack across a river creates a medical problem comparable to that of the amphibious assault. In order to provide treatment and reduce cross-river evacuation, medical elements cross as soon as combat operations allow. Early crossing of treatment elements reduces turnaround time for all crossing equipment which must load patients on the far shore. All possible use is made of air evacuation to prevent excessive buildup of patients in far-shore treatment stations. Near-shore treatment stations to reduce ambulance shuttle distances from off-loading points are placed as far forward as assault operations and protective considerations permit.

b. In defensive operations, medical resources deployed on the far shore are restricted to the least amount required to provide adequate support. To prevent undue accumulation of patients forward of the river, evacuation of far-shore treatment stations is expedited by the use of surface and air evacuation. Near-shore treatment stations are located farther to the rear than in the attack to prevent their displacement in a cross-river withdrawal.

CHAPTER 5

MEDICAL SUPPORT IN INTERNAL DEFENSE AND INTERNAL DEVELOPMENT

5-1. General

a. Internal defense is the full range of measures taken by a government and its allies to free and protect its society from subversion, lawlessness, and insurgency. Internal development is the strengthening of the roots, functions, and capabilities of government and the viability of its nation's life towards the end of internal independence and freedom from conditions fostering insurgency.

b. Stability operations are those types of internal defense and internal development operations and assistance provided by the armed forces to maintain, restore, or establish a climate of order within which responsible government can function effectively and without which progress cannot be achieved.

c. For many nations facing internal or external threats to their national security and independence, the United States provides economic and military assistance to help prevent or defeat the threat. United States foreign assistance supports both the attainment of internal development and internal defense objectives of the host country. Internal development assistance is provided under the foreign aid program administered by the Agency for International Development (AID) under the supervision of the Department of State. Internal defense assistance is provided under the Military Assistance Program (MAP) administered by the Department of Defense in coordination with the Department of State.

d. The support of the indigenous population for the host government is essential to prevent or defeat an internal security threat. Medical service has proven to be one of the most effective resources to gain support of the population. Medical assistance is constructive in nature and is generally welcomed rather than feared and rejected. The health hazards

prevalent in most developing nations and the general lack of medical personnel and facilities place a high premium upon United States medical services. AID programs assist host country civilian medical service, and in turn Army medical units may be employed to assist the AID program.

e. Internal defense assistance may be provided by United States military forces ranging in size from mobile training teams to a force as large as a field army. Tasks vary from providing advisory assistance to full-scale tactical operations.

5-2. Coordination

While the Army Medical Service participation in internal development operations is conducted as a part of a single U.S. health program, division or combat force Army Medical Service units remain organizationally separated as a military undertaking of the AMEDS personnel. Precise coordination between the division G5 (Civil Affairs), and the host country and with U.S. AID programs is imperative to provide a well-integrated, non-duplicated medical support program.

5-3. Stability Operations

When U.S. combat forces are deployed in stability operations, medical service units also will be deployed. These units will provide medical support for committed forces and perform medical civic action.

a. Medical civic action programs for the population are contingent upon the availability of resources and are subordinate to the needs of the combat forces. Medical support may include—

(1) Provision of medical treatment and patient-holding capabilities at lower echelons of medical service than is normal, such as area control bases, and security detachments. Patients to be evacuated by ground transport are

held until movement by means of a secure convoy is arranged.

(2) Provision of sufficient ground means to move medical units or elements.

(3) Use of air evacuation whenever possible.

(4) Provision of small medical elements to furnish unit level medical support to tactical units on long-range missions.

(5) Assignment to mobile units of specially trained medical personnel, capable of operating medical treatment facilities for short periods of time without immediate supervision by a Medical Corps officer.

(6) Formation of non-U.S. litterbearer teams to accompany combat units where terrain or other obstacles preclude transportation or evacuation of patients by other means.

(7) Strict supervision of sanitation, maintenance of individual medical equipment, and advanced or special first aid training throughout the division.

(8) Emphasis on basic combat training of medical service personnel, arming of medical service personnel, and the use of armored personnel carriers for ground evacuation.

(9) The use of allied medical resources and capabilities whenever they are available.

b. Medical civic action is the medical action provided to civilians which contributes to the general welfare and serves to improve the standing of the United States or the host country with the population. Although some medical civic action will be performed in all levels of conflict, its greatest use and importance are in stability operations. Basic principles of medical civic action are—

(1) Medical civic action will not be undertaken at the expense of medical service for U.S. personnel.

(2) The basic purpose of medical civic action is to gain, restore, or maintain public confidence in the host government and its military forces and allies, but such programs should not be identified openly with the psychological operations program.

(3) Medical civic action cannot be expected to solve the medical problems of a nation; rather, it is a supplement to the public

health program with which it must be coordinated.

(4) Medical civic action programs should extend host government public or private health facilities in remote or unsafe areas, but not duplicate or otherwise compete with established health services.

(5) Emphasis is directed toward solving simple medical problems benefiting the maximum number of people, rather than trying to treat the major problems of a few people. Serious illness requiring long-term treatment is referred to the civilian public health service for treatment; however, provision of transportation to a civilian hospital is a normal function of medical civic action.

(6) Maximum long-term benefits are achieved by teaching personal hygiene and sanitation.

(7) Civilians who are injured as a result of military operations receive priority treatment.

(8) Medical civic action is coordinated with the G3 and G5 to focus the effort where needed, and to assure compatibility with operations.

5-4. Medical Assistance in Developing Nations

Army medical personnel deployed in developing nations can expect to find poor health and sanitation conditions in many areas. Such conditions may include inadequate water supply and sewage disposal facilities, insufficient housing, lack of sanitation control, and inadequate medical care facilities. Medical units have a high potential of making a significant contribution to the internal defense and internal development effort. Initially, outright gifts, direct medical service, and U.S.-manned medical activities may be necessary to gain the confidence of the indigenous population. Because of the lack of local capability, medical planning for civic action must embody the principles stated in FM 41-10 and FM 31-23 and should have, as its basic planning factor and ultimate goal, the civic action credo of "helping the people help themselves." United States medical service participation should involve local military forces and include the

training and organization of the forces to carry out medical civic action programs and, in every way possible, enhance the status of local authorities. Any or all of the following measures may be adopted as appropriate and feasible:

a. Teaching and training individuals or small groups in basic concepts of personal hygiene and sanitation at a level which will meet the requirements and desires of the host country.

b. Providing emergency medical treatment and training indigenous personnel in methods of the treatment of disease and injuries.

c. Furnishing medical supplies.

d. Using Army ambulances for evacuation.

e. Providing emergency dental treatment and preventive dentistry support.

f. Conducting an immunization program.

g. Immunizing and treating domestic animals.

CHAPTER 6

AEROMEDICAL EVACUATION

(STANAG 2087 (SEASTAG 2087))

6-1. General

The helicopter's capability to circumvent enemy positions, overfly unfavorable terrain, and operate from confined or otherwise inaccessible areas increases the responsiveness and flexibility of the Army Medical Service evacuation system.

6-2. Mission

a. The primary mission of air ambulances is to provide aeromedical evacuation of patients.

b. The secondary mission of air ambulances is to provide movement of medical personnel, supplies, and equipment.

6-3. Capabilities

The capabilities of the aeromedical evacuation system are directly proportional to the types and numbers of air ambulances available. Factors which may limit the availability of air ambulances are flight time, weather conditions, aircraft maintenance problems, pilot availability, pilot fatigue, and enemy or friendly tactical activities within the operational area. The aircraft's patient-carrying capacity, speed, range, and weather restrictions vary with each type of air ambulance employed.

6-4. Operations

a. Aeromedical evacuation within the combat zone is provided by medical air ambulance companies and medical detachments (air ambulance). These units operate under the command and control of a medical group headquarters with a preferred allocation of one detachment or platoon from the air ambulance company in support of each division and one company in general support of each corps.

b. Air ambulances are used as far forward as combat conditions permit, including locations beyond the line of contact. The necessity of maintaining tactical security and protection

for the air ambulances and medical personnel must be considered when selecting patient pickup sites. Air ambulances should be used only when the landing area is reasonably secure from hostile fire. This may be defined in practical terms as being sufficiently secure so that a member of the unit requesting pickup will stand in the landing area and guide the approach of the air ambulance. If this degree of security does not exist, the unit requesting the evacuation must request airstrikes or ground artillery suppressive fires to eliminate the enemy threat in the vicinity of pickup.

c. When providing support to a division or brigade, aeromedical evacuation elements will use the division rear or a brigade base/trains as a base of operations. Aeromedical evacuation elements will provide evacuation from forward positions or battalion aid stations to either battalion aid stations, division clearing stations, or hospitals. In the event the supported force operates at an extended distance from the support base, the air ambulance unit in direct support performs intradivision or brigade evacuation missions only. Further evacuation from the brigade or division is provided by air ambulances in general support.

d. Crewmembers of air ambulances must remove firearms and explosives in possession of patients to preclude accidental detonation while loading or in transit to a medical treatment facility.

6-5. Procedures for Requesting Service

a. Since the majority of requests for aeromedical evacuation originate in the divisions, the basic concept of mission control is oriented to this requirement. Mission control is given to the division medical battalion commander. The medical battalion commander must establish priorities and resolve conflicting requirements based on sound, professional judgment.

b. Mission requests will be processed through the fastest and most reliable means available (fig. 2-11). A sole-user channel is desirable for the expedient transmission of aeromedical evacuation requests. Requests ordinarily flow from combat platoon or company, to battalion, to brigade, to supporting medical company, and then to the supporting air ambulance element (para 2-21e(1)(c)). Surgeons at all levels may monitor requests and indicate priorities (fig. 2-11).

c. All aeromedical evacuation requests must include, but not be limited to,—

- (1) Requesting unit.
- (2) Number of patients to be evacuated.
- (3) Type of wound, injury, or illness.
- (4) Priority (e.g., urgent, priority, routine).
- (5) Exact location of the pickup site by

grid coordinates.

- (6) Method of marking pickup site.
- (7) Time patients will be ready for evacuation.
- (8) Requests for emergency resupply or special equipment required.
- (9) Security status of pickup site.

d. Upon receipt of a mission request, the operations officer, clerk, or evacuation pilot coordinates the flight route and secures airspace clearance from the division base airfield or the flight operations center. Detailed information should be included in SOP (FM 1-60 and FM 1-105).

e. When air ambulance service is not available, the medical battalion commander or his representative requests the use of nonmedical aircraft from the division aviation officer.

CHAPTER 7

GENEVA CONVENTION AND PRISONERS OF WAR

7-1. General

In the treatment of prisoners of war, protection of medical personnel, and marking of medical facilities and transports, the United States is governed by the provisions of the Geneva and Hague Conventions, and the customary rules, both written and unwritten, of land warfare. The governing motives of these agreements are oriented toward a deferential approach to the medical aspects of war and the humane treatment of prisoners by the parties in a conflict (FM 19-40 and FM 27-10).

7-2. Prisoners of War and Retained Personnel

The Army is responsible for prisoners of war from the moment of capture. Below brigade level, PWs are handled by combat troops who bring them to brigade collecting points. Sick, injured, or wounded prisoners are treated and evacuated through normal medical channels but are segregated from United States and Allied patients.

a. Prisoner-of-war patients will be evacuated from the combat zone as soon as possible. Only those prisoners who are wounded or sick and would run a greater risk by being immediately evacuated may be temporarily kept in the combat zone. The necessity for providing and obtaining guards for PWs must be decided by higher authority.

b. Personnel of the enemy medical service or medical units who are captured and retained are considered retained personnel and not prisoners of war. They shall, however, receive the benefits and protection of the Geneva Convention and may be required to treat prisoners of war. Other medical personnel, though not attached to the medical service of their armed forces, and who are physicians, surgeons, dentists, nurses or medical

orderlies may be required to use their medical knowledge in the interest of prisoners of war. These medical personnel, however, are considered to be prisoners of war but they receive the same treatment as the corresponding retained medical personnel. Retention for duty in a treatment facility, however, must be authorized by higher authority.

c. The mobility of medical units supporting tactical operations must not be jeopardized by prisoner-of-war or nonmilitary patient workloads. When intelligence sources indicate that large numbers of PWs may result from an operation, medical units may require reinforcement by field army medical evacuation and treatment units to support the PW patient workload. This reinforcement permits division medical units to continue support of combat operations.

7-3. Self-Defense

Medical personnel may carry arms for personal defense and for the protection of the wounded and sick in their care. Overall security defense plans must not require medical units to take offensive action against enemy troops. Medical personnel are permitted to fire on enemy troops only when medical troops, individuals, or patients have been attacked. Personnel who use arms in violation of the laws of war are subject to penalties related thereto and, provided they have been given due warning to cease such acts, may also forfeit the protection of their unit or the unit they are supporting.

7-4. Protection and Identification of Medical Personnel

a. Medical personnel shall wear, affixed to the left arm, a water-resistant armlet bearing the distinctive emblem.

b. Such personnel, in addition to wearing the identifying emblem, shall also carry a special identity card bearing the distinctive em-

blem. This card shall be water-resistant and of such size that it can be carried in the pocket. It shall be worded in the national language, mention at least the surname and first names, the date of birth, the rank and the service number of the bearer, and shall state in what capacity he is entitled to the protection of the Convention. The card shall bear the photograph of the owner and his signature, or fingerprints, or both. The card shall be embossed with the stamp of the military authority.

7-5. Marking of Medical Units and Establishments

The distinctive flag of the Convention shall be hoisted only over such medical units and establishments as are entitled to be respected under the Convention, and only with the consent of the military authorities. The use of camouflage in the field is a command decision. Marking of facilities and the use of camouflage are incompatible and should not be attempted concur-

rently. Use of the red cross is authorized; however, the tactical commander may not want such distinctive markings displayed in his area.

7-6. Marking of Ambulances

a. Medical vehicles (ambulances) exclusively employed for the removal of wounded and sick or for the transport of medical personnel and equipment shall not be attacked. Ambulances will not be used to transport nonmedical troops or war materiel.

b. Air ambulances will be marked with a red cross centered on a field of white. Other markings or means of identification agreed upon at the outbreak or during the course of hostilities also will be provided.

c. Ground ambulances will be marked with the distinctive emblem on the top, both sides, and back.

d. Distinctive marking normally will be used unless otherwise directed by the tactical commander. See also paragraph 7-5.

CHAPTER 8

DIVISION MEDICAL SERVICE IN NUCLEAR WARFARE AND CHEMICAL AND BIOLOGICAL OPERATIONS

Section I. GENERAL

8-1. Purpose and Scope

This chapter provides guidance for medical service support in nuclear warfare and in biological and chemical operations. Placing this material in a separate chapter does not imply that these operations are to be considered as forms of special warfare; rather, that the lack of experience in these forms of warfare indicates the need to consolidate basic principles previously stated. The material presented provides emphasis and cohesiveness of thought for contingency planning of medical support, particularly those immediate problems confronting the Army Medical Service following an enemy attack. The influx of large numbers of casualties or the loss of medical facilities and personnel from multiple nuclear attacks, high-yield nuclear weapons, or chemical/biological agent attack will impair medical service. Concepts to use the remaining resources effectively will be discussed.

8-2. Basic Principles

a. In nuclear attacks, instead of a predominance of high-velocity missile wounds, many more burns, low-velocity missile wounds, and ionizing radiation injuries can be expected. Casualties will be produced faster and locally available means for early resuscitative care may quickly prove inadequate.

b. Chemical/biological operations and some nuclear bursts may produce militarily significant contamination and materially increase operational problems. Commanders must consider this contamination in planning under the threat or actual use of nuclear weapons or chemical/biological agents by the enemy.

c. Although the casualty impact will be in direct proportion to the number of divisional units involved, the division medical service is organized to provide support for conventional

warfare only. Plans for reinforcements from field army resources for personnel, equipment, and supplies must be made in advance. The division surgeon insures that the commander is aware of this potential requirement.

d. Civilian casualties may be a significant problem in populated areas and the Army Medical Service may be required to assist civilian casualties when civil medicine cannot handle the problem. Aid to civilians, however, will not be undertaken at the expense of essential medical service for U.S. personnel.

e. In planning for medical support following enemy nuclear or chemical/biological attack, every effort must be made to conserve and achieve the best possible use of available medical personnel (TM 8-285).

(1) Each individual must be trained to apply first aid to himself (self-aid) and to others (buddy-aid) (FM 21-11, FM 21-40, and FM 21-41). First aid training of nonmedical personnel for nuclear casualties should stress simple treatment techniques based on improvisations with available materials.

(2) Each physically capable individual is responsible for carrying out required decontamination of himself and his equipment as soon as possible. The medical service is responsible only for the decontamination of patients who have reached medical facilities and are unable to perform self-aid.

(3) Trained medical personnel should be used primarily to provide emergency medical care or, if time and resources permit, more detailed treatment. Nonmedical personnel should provide for search and rescue of the injured or wounded, immediate first aid, and initial chemical agent decontamination. Nonmedical vehicles should be used to supplement the movement of casualties to the initial medical treat-

ment facility. Unit medical service personnel will be employed as indicated in chapter 2.

(4) Dental officers and assistants will be most profitably used in providing emergency medical treatment.

f. Decontamination stations must be established at treatment facilities and should be conveniently located for the flow of patient traffic, with consideration given to the principles indicated in TM 3-220. Patients should not be admitted to decontamination stations, medical facilities, or other inclosed spaces in clothing or blankets known to be contaminated. Proper steps also must be taken to obtain timely replacement of items made unusable by contamination and to insure the decontamination of such equipment. Patients should be decontaminated, whenever possible, prior to evacuation by aircraft or ground vehicles. When this is not possible, hazards to other persons may be reduced by following simple procedures as stated in TM 8-285. Nuclear and chemical casualties must be considered separately as follows:

(1) *Chemical.*

(a) A frequent problem at the treatment facility will be to determine whether the surgical condition or the chemical agent hazard requires priority of attention.

(b) At the earliest practicable moment and with due consideration given to the condition of the patient, clothing and equipment contaminated with chemical agents should be removed from the patient and decontamination started.

(c) The rapidity and irreversible nature of reaction to some of the chemical agents, especially the nerve agents, dictate that treatment of affected individuals be started as soon as possible after symptoms appear.

(2) *Nuclear.* Since the physical injuries resulting from nuclear blasts and heat will be of greater immediate significance to the individual than radiological contamination, consideration always should be given to providing first aid or emergency medical care before decontamination begins.

g. Detailed information on chemical, biological, and nuclear defense is contained in FM 21-40. Detailed guidance on the widely

varying possible doses of radiation is contained in FM 3-12.

8-3. Medical Planning Factors

a. Definitive planning and coordination are mandatory at all command levels in an effort to provide adequate medical support. This includes provision for treatment, evacuation, and hospitalization. Higher headquarters should distribute timely plans and directives to subordinate units. Provisions for emergency medical care of civilians, consistent with the military situation, must be included.

b. The surgeon, although not responsible for casualty estimates, should make a quick appraisal to determine the medical requirements. Medical support will not be delayed pending such estimates.

c. In developing medical plans, the commander should consider various simplified and standardized procedures for patient care in the postattack emergency phase, thus allowing less qualified medical personnel to perform treatment. Personnel proficiency must be acquired by training.

8-4. Area Damage Control and Estimation

a. Area damage control operations are those measures taken before, during, or after hostile action or natural or manmade disasters to reduce the probability of damage and reduce its effects. Each commander is responsible for his area damage control measures and will contribute, within his capabilities, to the overall area damage control operations.

b. The division G4 has general staff responsibility for the division area damage control operations.

c. The division support command commander is responsible for the detailed planning and execution of area damage control operations for combat service support units and essential routes located within the division support area. He also insures that the plans conform to the overall division plan.

d. Control and assessment teams (CAT) are organized by all division units. Each CAT estimates the types and numbers of casualties and the remaining effective strength of units. The senior member of the team submits reports through command channels by the most rapid means.

e. A medical officer may be designated to assist the CAT in preparing the medical plan. Subarea medical service primarily consists of establishing and operating treatment or sorting stations at the periphery of the damaged area. These stations function similarly to unit aid stations.

f. For efficient operation, treatment units should retain their integrity and not be fragmented to provide teams for use in the damaged area.

8-5. Medical Sorting

a. Medical sorting is the classification of patients, according to the type and seriousness of injury, and the establishment of priorities for treatment or evacuation, or both, to insure the greatest benefit to the largest number. This achieves the most orderly, timely, and efficient use of medical resources. The categorization of patients will vary with the military situation, patient backlog, and available medical means. The following are examples of patient categories:

(1) *Minimal*. Individuals who can be returned to duty immediately.

(2) *Immediate*. Patients requiring immediate treatment to save life or limb.

(3) *Delayed*. Patients who, after emergency care, incur little additional risk by delay in further treatment.

(4) *Expectant*. Patients so critically injured that only complicated and prolonged treatment offers any appreciable improvement in life expectancy.

b. For additional information, see TB MED 246.

8-6. Reinforcement of Medical Support

During nuclear and chemical and biological operations medical requirements may increase and temporary medical reinforcement will be necessary. Planning at all appropriate command levels must provide for the equitable allocation of medical means for the support of the tactical mission as well as area damage control operations. Support may be required from nonmedical units. Subject to the provisions of the 1949 Geneva Conventions, civil af-

fairs units may provide indigenous personnel to assist in both military and civilian patient collection, treatment, and evacuation. Civilian assets in the area of attack probably will be required for collection and treatment of civilian casualties. Prisoners of war may also be used.

8-7. Unit Disposition

Target analysis determines areas most vulnerable and profitable for enemy attack. Planning considerations must weigh the value of placing medical facilities away from such target areas with adequate dispersion in accordance with the operational requirements of the unit.

8-8. Communications

The responsible medical officer in the damaged area will use all available communications to coordinate medical activities. Radios or telephones may be available at the incident post (command post of the CAT commander). The use of runners, vehicle drivers, and aircraft pilots should not be overlooked.

8-9. Nuclear, Biological, and Chemical Warfare Casualties

Treatment and evacuation of nuclear and chemical casualties will be based upon presenting signs and symptoms. Following a nuclear attack, individuals suspecting radiation injury may reach the treatment facility seeking medical attention. Suspected nuclear radiation injury alone, without specific symptoms and physical findings, will not justify evacuation. Ordinarily, in nuclear and conventional warfare, burns or traumatic injury will be the basis for early medical care and evacuation. SOP will govern the use of prophylactic measures following known or suspected biological agent attack.

8-10. Medical Supplies

Current regulations direct medical treatment facilities and depots to maintain specified amounts and types of emergency supplies above their prescribed levels. Medical plans must provide for establishing emergency supply points and for the delivery of specified emergency medical supplies.

Section II. SPECIAL OPERATIONS

8-11. General

The possibility of enemy employment of nuclear warfare and chemical and biological operations in such areas warrants additional consideration. The principles of medical service, as previously discussed, are applicable in extreme climates and terrain. Consideration must include peculiarities of such operations and related effects upon prompt or delayed medical treatment, evacuation, and hospitalization.

8-12. Mountain Operations

In mountain operations, units may be widely dispersed. Such terrain may support only limited troop concentrations. Fewer targets may exist; therefore, fewer casualties may be anticipated. Logistical problems, including evacuation, will increase. Medical resources are spread over a wide area. Mountain passes and defiles may tend to canalize nuclear blast and chemical effects. Ridges and steep slopes may offer shielding from thermal radiation. Roads and railways may be nonexistent or of very limited usability, thus restricting movement and complicating evacuation. A greater reliance on aircraft can be expected.

8-13. Operations in Snow and Extreme Cold

The effect of cold in addition to radiation injury is unknown; however, with traumatic injuries cold hastens the progress of shock and

provides a less favorable prognosis. Exposure to the weather can also cause additional injury, such as frostbite, and necessitates the provision of warm, protected areas for patients while being treated or awaiting evacuation. Reflection of thermal radiation from snow and ice-covered areas will tend to reinforce the incident radiation. Burns will, therefore, be more severe, especially on exposed skin surfaces.

8-14. Jungle Operations

In rain forests and other jungle areas, the overhead canopy will tend to shield from thermal radiation and thereby reduce this specific burn potential. The canopy, too, will increase the persistency effect of some of the chemical agents. Vegetation ignited by thermal radiation must not be overlooked as a source of fire and burn injuries. There may be, proportionately, more trauma and ionizing radiation injuries. Tree blowdown will further complicate movement and require greater reliance on improvised methods of evacuation.

8-15. Desert Operations

Troops may be widely dispersed due to absence of natural obstacles and, therefore, present less profitable targets. Because of lack of concealment and cover, troops will be more exposed. Additionally, smooth sand is a good reflector of both thermal and blast effects; therefore, these effects may be greater with an attendant increase in thermal and mechanical injuries.

CHAPTER 9

SUPPORTING MEDICAL SERVICE

9-1. General

a. The division (separate brigade) medical service provides unit and division level medical support. The next level of medical support, field army level, is provided by the medical brigade of the field army support command.

b. The medical brigade supports the division. (FM 8-16, FM 8-16-1 (TEST), and FM 54-8 (TEST)). Only those units of the medical brigade that might be located in the division area are discussed in the following paragraphs. Detailed discussion will be found in cited references.

9-2. Evacuation

a. Separate medical ambulance companies evacuate patients from division (separate brigade) clearing stations and mobile army surgical hospital to hospitals to the rear of the division boundary. Under certain circumstances, ambulances may be dispatched to assist in evacuation at battalion aid stations. Normally, one ambulance company supports each committed division.

b. Medical detachments (helicopter ambulance detachment), or a platoon of a medical air ambulance company, may be in support of a division or separate brigade. They provide aeromedical evacuation for patients and the movement of medical personnel, equipment, and supplies as required.

c. A medical collecting company may provide litterbearers to be used in the division area to assist in evacuation. In addition, platoons or sections of these companies may be used at clearing stations or mobile army surgical hospitals to assist in loading and unloading ambulances.

9-3. Hospitalization

Mobile army surgical hospitals provide resuscitative surgery and the medical treatment necessary to save life or limb and prepare critically injured or ill patients for further evacuation. These hospitals may be located with one of the medical companies of the division medical battalion, or behind the division rear boundary. The usual allocation is one hospital for each division.

APPENDIX A

REFERENCES

AR 10-1	Functions of the Department of Defense and Its Major Components
AR 10-5	Department of the Army
AR 40-1	Composition, Mission, and Functions of the Army Medical Service
AR 40-3	Medical, Dental, and Veterinary Care
AR 40-4	Army Medical Service Facilities
AR 40-5	Preventive Medicine
AR 40-216	Neuropsychiatry
AR 40-400	Individual Medical Records
AR 40-417	Morbidity Reports, Tables, and Charts
AR 320-5	Dictionary of United States Army Terms
AR 320-50	Authorized Abbreviations and Brevity Codes
AR 600-10	The Army Casualty System
AR 611-101	Manual of Commissioned Officer Military Occupational Specialties
AR 611-201	Manual of Enlisted Military Occupational Specialties
AR 633-50	Prisoners of War; Administration, Employment, and Compensation
DA PAM 350-15-2	Operations, Lessons Learned
FM 1-15	Divisional Aviation Battalion and Group
FM 1-60	Army Aviation Air Traffic Operations—Tactical
FM 1-100	Army Aviation Utilization
FM 1-105	Army Aviation Techniques and Procedures
FM 3-10	Employment of Chemical and Biological Agents
FM 3-12	Operational Aspects of Radiological Defense
FM 5-135	Engineer Battalion, Armored, Infantry, and Infantry (Mechanized) Divisions
FM 5-136	Engineer Battalion, Airborne and Airmobile Divisions
FM 6-140	Field Artillery Cannon Battalions and Batteries
FM 7-20	Infantry, Airborne Infantry, and Mechanized Infantry Battalions
FM 8-10	Medical Service, Theater of Operations
FM 8-16	Medical Service, Field Army
FM 8-16-1 (TEST)	Medical Service, Field Army
FM 8-17-1 (TEST)	Medical Service, Communications Zone
FM 8-55	Army Medical Service Planning Guide
FM 11-50	Signal Battalion, Armored Infantry and Infantry (Mechanized) Divisions
FM 11-57	Signal Battalion, Airborne Division
FM 17-1	Armor Operations
FM 17-15	Tank Units, Platoon, Company, and Battalion
FM 17-30	The Armored Division Brigade
FM 17-36	Divisional Armored and Air Cavalry Units
FM 17-95	The Armored Cavalry Regiment
FM 19-40	Enemy Prisoners of War and Civilian Internees
FM 21-11	First Aid for Soldiers

FM 8-15

FM 21-40	Chemical, Biological, and Nuclear Defense
FM 21-41	Soldier's Handbook for Defense Against Chemical and Biological Operations and Nuclear Warfare
FM 27-10	The Law of Land Warfare
FM 31-12	Army Forces in Amphibious Operations (The Army Landing Force)
FM 31-13	Battle Group Landing Team (Amphibious)
FM 31-16	Counter guerrilla Operations
FM 31-23	Stability Operations, U.S. Army Doctrine
FM 31-25	Desert Operations
FM 31-30	Jungle Training and Operations
FM 31-71	Northern Operations
FM 31-72	Mountain Operations
FM 41-10	Civil Affairs Operations
FM 54-2	The Division Support Command
FM 54-8 (TEST)	The Administrative Support, Theater Army (TASTA-70)
FM 57-35	Airmobile Operations
FM 61-100	The Division
FM 100-5	Field Service Regulations—Operations
FM 100-10	Field Service Regulations—Administration
(C)FM 100-20	Field Service Regulations—Internal Defense and Development (IDAD)
	(U)
FM 101-5	Staff Officers' Field Manual: Staff Organization and Procedure
FM 101-10-1	Staff Officers' Field Manual Organization, Technical, and Logistical Data
	(Unclassified Data)
TB MED 246	Medical Management of Casualties in Nuclear Warfare
TM 3-215	Military Chemistry and Chemical Agents
TM 3-216	Military Biology and Biological Agents
TM 8-244	Military Psychiatry
TM 8-285	Treatment of Chemical Agent Casualties

APPENDIX B

INTERNATIONAL STANDARDIZATION AGREEMENTS

NATO—UNCLASSIFIED

STANAG No. 2061 (SEASTAG 2061,
CENTO STANAG 2061, SOLOG 66)

DETAILS OF AGREEMENTPROCEDURES FOR DISPOSITION BY MEDICAL INSTALLATIONS
OF ALLIED PATIENTS

1. GENERAL

It is agreed that the NATO Armed Forces will use the standard procedures for disposition by Medical Installations of Allied Patients indicated in the paragraphs shown below.

The procedures outlined herein are based on the principles which should govern the return of patients received in Allied Medical Installations to their own National Organizations.

2. TRANSFER OF PATIENTS

- a. The medical welfare of the patient must be the paramount consideration. When deciding upon the transfer of a patient, due consideration should be given to any increased medical hazard which the transfer might involve.
- b. Arrangements for disposition of the patients should be capable of being implemented by existing organizations. Consequently, no new establishment should be required specially for dealing with the transferring of allied casualties.
- c. Patients will be transferred to their own national organization at the earliest practicable opportunity consistent with the observance of principles established in paragraphs a and b above, and under any of the following conditions:
 - (1) When a medical facility of their own nation is within reasonable proximity of the facility of the holding nation.
 - (2) When the patient is determined to require hospitalization in excess of thirty days.
 - (3) When there is any question as to the ability of the patient to perform duty upon release from the hospital.
- d. The decision as to whether a patient, other than those requiring transfer under 2c above, is fit for release from the medical treatment facility is the responsibility of the commander of the medical facility treating the patient.

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- e. All clinical documents, to include X-rays, relating to the patient will accompany him on transfer to his own national organization.
- f. The decision for suitability for transfer and the arrangements for transfer will be the responsibility of the holding nation.
- g. Final transfer channels should be arranged by local liaison before actual movement.
- h. Patients not suitable for transfer to their own national organization must be dealt with for treatment and disposition purposes as patients of the holding nation until they are transferred, i.e., they will be dealt with either in military hospitals, military medical installations, or in civilian hospitals that are part of the military medical evacuation system of the holding nation.

3. CLASSIFICATION OF PATIENTS

Different channels for disposition will be required for the following two types of cases:

- a. Patients Not Requiring Admission
Patients not requiring admission to a medical unit will be returned to their nearest national unit under arrangements to be made locally.
- b. Patients Who Have Been Admitted to a Medical Installation
All such patients will be dealt with in accordance with paragraph 2 above.

STANAG No. 2075

DETAILS OF AGREEMENTPATIENT REPORTING BY MEDICAL TREATMENT FACILITIES

GENERAL

- 1. This agreement takes into account the fact that any one National medical formation/unit in a force may admit, transfer and discharge nationals of the other NATO countries. Further, that each medical formation/unit has the responsibility for notifying the national authority concerned of information concerning casualties of that nation, either direct or through the reporting nation's staff channels.
- 2. It is agreed that the NATO Armed Forces will follow the procedures set forth herein so that patient reporting between nations will be standardized.

PROCEDURES

- 3. Medical treatment facilities which administratively admit patients (some are described below) will prepare daily separate lists of admissions, transfers and discharges of personnel of each NATO nation serving in the Force.
- 4. These lists (paragraph 3) will contain the information detailed in paragraph 9 below, and will cover the period 0001 hours to 2400 hours, being serially numbered.
- 5. The lists will be dispatched to medical authorities to be detailed by the Force Commander.

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6. Special lists will be maintained of patients considered by the appropriate medical authority to be Very Seriously Ill and/or Seriously Ill. The placing on or removal from these lists of a patient will be made known by fastest means to the authorities detailed in accordance with paragraph 5.
7. a. Notification of deaths in medical installations will be made by fastest means to the authorities detailed in accordance with paragraph 5, showing cause of death.
- b. Notification of loss of a hand(s), foot (feet), limb(s), or eye(s) will be made to the authorities detailed in accordance with paragraph 5.

MEDICAL LEVEL OF NOTIFICATION

8. The following equation of some NATO medical installations is given for illustrative purposes only. Notification in accordance with preceding paragraphs would normally be made by the installations underlined:

UK	US	FR
Regimental Aid Post	Battle Group (Bn) Aid	Corps Medical Unit
Casualty Clearing	None	<u>Medical Company</u>
Post		
<u>Advanced Dressing</u>	<u>Clearing Station</u>	<u>Medical Battalion</u>
<u>Station</u>		
<u>Casualty Clearing</u>	<u>MASH & Evac.</u>	<u>Field Hospital</u>
<u>Station</u>	<u>Hospitals</u>	
<u>Hospital (forward)</u>	<u>Hospital (station/</u>	<u>Hospital (forward)</u>
	<u>field)</u>	
<u>Hospital (rear)</u>	<u>Hospital (general)</u>	<u>Specialized Fwd</u>
		<u>Hospital</u>
		<u>Hospital (rear)</u>

PATIENT REPORTING

9. The following details will be the minimum shown on all lists issued under the preceding paragraphs:

- a. Designation and nationality of medical unit issuing list.
- b. Serial number and date of issue of list.
- c. Personal number of each casualty.
- d. Rank/grade of each casualty.
- e. Surname and initials of forenames of each casualty.
- f. Unit/Regiment of each casualty.
- g. Nationality of the casualty's Unit/Regiment.
- h. Diagnosis (also showing whether Very Seriously Ill (V.S.I.) or Seriously Ill (S.I.) and indicating if loss of a hand(s), foot (feet), limb(s) or eye(s) has occurred.)
- i. Categorization:
 - (1) Battle Casualty (BC)
 - (2) Non-Battle Accident/Injury (NBA/NBI)
 - (3) Sick/Disease (S/D)

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- j. Date of:
 - (1) Admission.
 - (2) Transfer out, or
 - (3) Discharge.
- k. Unit to which transferred or discharged (show nationality or unit)
- l. If died, to be shown as DIED giving date.

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NAVY/ARMY/AIR

DETAILS OF AGREEMENT (DofA)MEDICAL AND DENTAL SUPPLY PROCEDURES**AGREEMENT**

1. The NATO Armed Forces have agreed to adopt for the use by their Medical Services:

- a. Standardized procedures for the exchange, at all levels within a Theatre of operations, of non-expendable items of medical and dental property required to accompany patients during the process of evacuation from the battlefield to the appropriate medical and dental unit.
- b. The metric system of weight and measures for dosage information on the labels of medical supplies.
- c. Standardized colours and procedures to identify the contents of atropine and morphine self-injection devices.

MEDICAL AND DENTAL EXCHANGE PROCEDURES

- 2. Each nation is to, if possible, return at once to the nation of origin any non-expendable item of medical or dental property accompanying patients of another nation received by them.
- 3. If it is not possible, items such as stretchers (litters), non-expendable splints, blankets, etc., are to be immediately replaced by the receiving nation who will hand over functional equivalent items in exchange for those received.
- 4. The handling of non-expendable items of medical or dental property are to, in general, conform to national procedures irrespective of the country of origin of the equipment.
- 5. Nevertheless, each nation is to undertake to segregate as soon as possible non-expendable items of medical or dental property belonging to another nation and return them to that nation through property exchange points.
- 6. Property exchange points at which items of equipment are sorted and exchanged with owner nations are to be arranged as circumstances may require at the appropriate levels related to the national administrative control and in accordance with the national supply procedures.
- 7. Each exchange point is to be staffed with personnel familiar with the items of medical and dental property peculiar to each nation.

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LABELS FOR MEDICAL SUPPLIES

8. Medical supplies to be used by the NATO Armed Forces are to be labelled with the metric system of weights and measures.

9. It is further agreed that where countries are in a transitional period (i.e., changing from avoirdupois to metric system) these countries are to label supplies with both metric and avoirdupois systems.

COLOURS FOR ATROPINE AND MORPHINE SELF-INJECTION DEVICES

10. One or more circular bands coloured BRIGHT RED are to encircle the syrettes and/or containers for morphine self-injection devices.

11. One or more circular bands, coloured BRIGHT YELLOW, are to encircle the syrettes and/or containers for atropine or equivalent self-injection devices.

12. Other markings may be placed, according to national legislation dealing with toxic matter, on the labels on morphine and atropine self-injection devices. However, the colours BRIGHT RED for morphine and BRIGHT YELLOW for atropine should be used.

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By Order of the Secretary of the Army:

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